First Peoples Child & Family Review
A Journal on Innovation and Best Practices in Aboriginal Child Welfare Administration, Research, Policy & Practice
Volume 4, Number 1, 2009, p. 4

Foreword

Ginger Gosnell-Myers,
Editorial Board Member of the First Peoples Child & Family Review

It is important to understand where we have been in order to move forward. Many of the authors in this journal acknowledge the important journey that our ancestors have taken in looking at where we are at today, and where we may be in the future. This is essential story telling for all our current generations as it contributes to the growing awareness that things are not right, the reasons why that may be, and ignites the fuel to make tomorrow a better day. While we are getting better at telling our stories, we are also strengthening our identities just by talking to each other at great length on all topics and exploring new ways of doing things – almost like a pioneering effort of investigating all that is available to those within general Canadian society.

Like those who first few who entered into University, there are now thousands in their place. And such will be so with past trail blazers and future politicians, philosophers, nation-builders, researchers (answer seekers) and care-givers. Our children will live vastly different lives than that of ourselves and our grandparents. The contents of this journal include works that aim to enhance the well being of our children and our future for Aboriginal children. The people who contribute to the journal are among the many that choose to walk in the footsteps of our ancestors, and pave the way for those yet to come.

In peace, Ginger Gosnell-Myers

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
Volume 4, Number 1, 2009, pp. 5-7

Editorial: The Legacy of a Child: Jordan's Principle

Christine Wekerle, Marlyn Bennett and Don Fuchs

It has been said that a child shall lead the way. There are lessons to be learned from the smallest among us (Koptie & Wesley-Esquimaux, this issue). The learning from a child's experience was a repeated key message at the "*Caring Across the Boundaries*" (CAB) conference held in Manitoba in late May 2009 (presentational material available on the web at: [http://www.fncaringsociety.org/cab-conference/). The CAB conference and the majority of the articles that appear in this issue of the journal were initiated by the story of a toddler named *Jordan* (see Blackstock, 2008). Honoring the memory of Jordan was key to kicking off the CAB conference because through his experience we learned the price that many First Nations children pay … unlike other other Canadian children born with complex medical needs, Jordan died before his needs could be addressed. Why? Because he was born to a First Nations family residing in a First Nation community! Jordan was an average child in some ways – loving teddy bears; yet, he was an extraordinary child in other ways – his little self incited a cry for social justice and ignited a posthumous movement to uphold human rights for all First Nations children through the creation of a child first principle called "Jordan's Principle" (Blackstock, 2008).

Jordan's Principle decrees that where a jurisdictional dispute arises between two government parties (provincial/territorial or federal) or between two departments or ministries of the same government regarding payment for any services to a Status Indian child which are otherwise available to other Canadian children, the government or ministry/department of first contact must pay for the services without delay or disruption. The paying government party can then refer the matter to jurisdictional dispute mechanisms. In this way, the needs of the child get met first while still allowing for the jurisdictional dispute to be resolved later (First Nations Child & Family Caring Society of Canada, 2007) (See background story at: http://www.fncaringsociety.org/more/jordansPrinciple).

Sadly, the reality is that Jordan's story is not unique among First Peoples' communities. Presentations made at the CAB conference clearly and poignantly pointed to data that reflected on the reality of the economics of being ia child in need on reserve versus off-reserve. These presentations as well as focused on the overlap between the special needs of children and parental efforts at coping (Badry, this issue). Fort instance, children with FASD represent over 17 % of all children in Care and 34% of all children with disabilities in care. First Nations children are significantly overrepresented in this group (Fuchs, Burnside, Marchenski & Mudry, 2007). These numbers are continuing to increase. Badry's article identifies the need for an additional range of cross disciplinary supports for children with FASD and their foster families. New standards for practice which provide more culturally appropriate service contacts have been shown to provide significant benefits for increasing the effective development outcomes for children with FASD in care and their foster families (Fuchs, 2008; Badry, this issue). The pressing issue is timely access to resources with jurisdictional delays that sees documents signed-off by too many governmental and service officials in a queue of so many documents and processes over days and months and years that count so dearly in a young life.

In the present issue, it is fitting to have the lead article written from a first-person perspective on First Peoples' maltreatment in terms of attachment disruption and traumatic separation from parents, siblings, extended family, community and cultural traditions (Montgomery-Reid, this issue). Trauma is compounded by prolonged emotional abuse in terms of verbal assaults on the child and isolation from caring adults and physical mistreatment for a child's natural behaviors. While child welfare is acknowledged as a protection system - and child safety is the foundation upon which normative child development proceeds - system-involved families have not been clearly evaluated in terms of trauma-based mental health and relationship issues

(Twigg & Hengen; Blackstock; Badry; Koptie & Wesley-Esquimaux, this issue). Post-traumatic stress disorder symptomatology reflects physical, psychological and physiological responses that include reactivity to intrusive components in the environment (i.e., a startle response to sudden, loud noise; an anticipatory fear-based response to maltreatment-similar situations, such as being physically close to someone, being consciously aware in the present moment; the ability to self-soothe in stress situations; the ability to self-protect and protect others in perceived danger situations; trauma event-related fears such as feeling trapped; losing control, being harmed, death etc.; see APA, 2004 for diagnostic criteria). However, developmental traumatology theory puts forward that disorder is not necessary to have trauma-related negative effects. An elevated stress response, which has to fatigue in some time periods and may appear as depression or the need to self-medicate or self-distract from responding to on-going stress, is itself, related to brain structural, functioning and perceptual alterations (e.g., DeBellis, 2001; Glaser, 2000). In connecting trauma to poor outcomes, the intervention is indicated: directly address the trauma symptomatology and the conceptualization of trauma's impact on development.

A trauma model is valid in explaining the unique impact of emotional abuse (beyond the effect of physical abuse, sexual abuse, and neglect) in predicting adolescent dating violence (Wekerle et al., in press). A trauma model has explained alcohol abuse among adults (Whiffen & MacIntosh, 2005), adolescent depression and suicidal ideation (e.g., Mazza & Reynolds, 1999), adolescent substance abuse (e.g., Tonmyr, Jack, Brooks, Kennedy Dudding., this issue) and Aboriginal youth substance abuse (Stewart et al., 2009). The maltreatment – Post-Traumatic Stress Disorder – negative outcome has been examined most among females and with respect to sexual abuse history (e.g., Havig, 2008). However, the maltreatment and the context within which the maltreatment occurred need to be considered (Zielinski & Bradshaw, 2006), particularly given the wide ranging impacts from migraine and chronic pain to gastrointestinal issues to mental health concerns and the evidence for efficacious prevention (e.g., MacMillan et al., in press). One key context remains poverty (LaFrance, this issue). More model programs and research on their effectiveness within the Aboriginal context are needed (Twigg & Hengen; Wortzmann; Badry, this issue). The plea for help is echoed by Harding's poem on maltreatment's sometimes unseen and unheard impact (this issue). The need for social work practice – and all clinical services – to evaluate harm, as well as health promotion or positive intervention outcomes is underscored by Blackstock (this issue). There is a need to utilize the research information that currently exists towards planning in ways that minimize the likelihood of harm (Tonmyr, Jack, Brooks, Kennedy, & Dudding, this issue). A community investment in research that focuses on similar concerns increases the likelihood that the research questions are formed with cultural competence (Twigg & Hengen; Stewart, this issue), and that the data collected is more relevant to practice and innovation oriented. With increasing scholarly and experiential attention and reflection (Stewart; Koptie & Wesley-Esquimaux, this issue), a way towards innovations in best practices and the knowledge translation of research to practice can be facilitated. In particular, success in having synchronization between evidence-based best practices and wise practices may ensue and answer the question: Does this way, this path, have a heart? (LaFrance, this issue).

References:

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th edition - Rev. ed.). Washington, DC: American Psychiatric Association.

Badry, D. (this issue)

Blackstock, C. (this issue)

Blackstock, C. (2008). Reconciliation means not saying sorry twice: Lessons from child welfare in Canada. In *From Truth to Reconciliation: Transforming the Legacy of Residential Schools,* prepared for the Aboriginal Healing Foundation by M. Brant Castellano, L. Archibald and Mike DeGagne. Ottawa, ON: Aboriginal Healing Foundation.

DeBellis, M. D. (2001). Developmental traumatology: The psychobiological development of maltreated children and its implications for research, treatment, and policy. *Development and Psychopathology*, 13(3), 539–564.

First Nation Child & Family Caring Society. (2007). *Joint Declaration of support for Jordan's principle: To resolving jurisdictional disputes affecting services to First Nation children*. Retrieved March 1, 2009, from http://www.fncaringsociety.org/docs/joint_declaration.pdf.

Fuchs, D., Burnside, L., Marchenski, S., & Mudry, A. (2007). *Children with FASD involved with the Manitoba child welfare system*. Available: http://www.cecw-cepb.ca.

Fuchs, D. (2008). *Children in care with FASD*. Presentation at the Caring Across the Boundaries: Bridging Knowledge Gaps, Services and Policies to Support Fist Peoples Child Welfare and Health Conference, May 28-30, 2008, Winnipeg, Manitoba.

Glaser, D. (2000). Child abuse and neglect and the brain-A review. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 41*, 97-118.

Harding, L. (this issue)

Havig, K. (2008). The health care experience of adult survivors of child sexual abuse.*Trauma, Violence & Abuse, 9*, 19-33.

Lafrance, J. (this issue)

Kopti, S. and C. Wesley-Esquimaux. (this issue)

Macmillan, H.L., Wathen, C.N., Barlow, J., Fergusson, D.M., Leventhal, J. M. & Taussig, H. N. (2009). Interventions

to prevent child maltreatment and associated impairment. *Lancet*, 2009, Jan 17; 373(9659): 250-66.

Mazza, J.J., & Reynolds, W. M. (1999). Exposure to violence in young inner-city adolescents : Relationships with depression, suicidal ideation, and PTSD symptomatology. *Journal of Abnormal Psychology, 27,* 203-213.

Montgomery, J. (this issue)

Tonmyr, L. Jack, Brooks, B. Kennedy and P. Dudding (this issue).

Twigg and Hengen (this issue)

Stewart, S. (this issue).

Wekerle, C., Chen, M., Leung, E., Waechter, R., & The MAP Research Team (in press). The Maltreatment and Adolescent Pathways (MAP) Project: A community action health research project on child protective services-involved teens. In N. Trocmé, S. Léveillé, I. Brown and C. Chamberland (Eds). *Research- Community Partnerships in Child Welfare.* Montreal: Mc-Gill-Queen's University Press.

Whiffen, V. & MacIntosh, H. (2005). Mediators of the link between childhood sexual abuse and emotional distress. *Trauma, Violence & Abuse, 6*, 24-39.

Wortzman, R. (this issue)

Zielinksi, D.S. & Bradshaw, C.P. (2006). Ecological influences on the sequelae of child maltreatment: A review of the literature. *Child Maltreatment, 11*, 49-62.

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YOUTH PERSPECTIVE: Reflections on Racism

White Feather Woman
(Jasmine Montgomery-Reid)

Bio

I come from a small town, Keremeos, British Columbia. My main hobby is playing basketball. I am 14 years and am a strong believer in my culture. I wrote this speech for a contest at my school and placed second. This speech is based on facts and personal experiences. I take this subject really seriously because I believe in a racist free world.

Way xast kelhalt iskwist Jasmine.

Hello my name is Jasmine.

Honestly have you ever said a racist comment to somebody? Have you ever had someone say something racist to you? Well I have and it hurts. It makes you feel badly about yourself. I believe racism is wrong. Here is what racism means to me - Mistreating people because of the colour of their skin.

Did you know that black people were used as slaves? Did you know that First Nations including my papa were sent to Church residential school at age 4 and did not return home until he was 14 years old? Just think about leaving your family to speak a language you never heard before or to live on food that was foreign to you or to be whipped every time you speak your language. STOP! Put yourself in my papa's shoes. How would you feel? Racism has hurt a lot of people including my family and yours. Racism is hurtful and wrong.

Wouldn't life be boring without some sports such as hockey? I mean, who here likes hockey? Well, First Nations invented Lacrosse then that was soon transformed into hockey. First Nations also invented pemmican (a.k.a. *jerky*). The Inuit invented the Kayak. Coloured people have made or invented a lot of other things probably more than you know. Everyone can contribute no matter the colour.

I don't know if you have ever heard of the Universal Declaration of Human Rights but it states that every human being is free and equal in dignity and rights. Not a lot of people have heard of that document but it is very important but nobody seems to care.

Now that I look at our history only a very famous activist named Martin Luther King Jr. stood up for our rights. As he stated in his most known speech: "I had a dream that one day this name will rise up and live out the true meaning of its creed. We hold these truths to be self evident that all men are created equal. Free at last. Free at last!"

You wouldn't think any of this stuff to be true but it is. We should just face it - Racism happens everywhere even in school. But all of us can make a difference by standing up for classmates or anybody because racism is wrong!

I thank you!

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POEM: Can You Hear Me Through the White Noise?

Laurie Harding

Can you **Hear** what I am telling you?
When I look away,
When I don't answer,
When I look blankly through you?

Do you **Want** to know?
Or is it too uncomfortable?
Too awkward?
Too ugly?

Speak to me with your Eyes,
Your Heart,
Your Soul,
Your Being.
Can you, hear me, see me, Feel my Pain?

Are you **Worth** my time?
Or is this all the same boring Rhetoric?
Hearing your-Self speak?

Already hearing what **You** want to know.
Validating
Measuring
Quantifying,
Proving **Your** point.

What about Mine?
Does it even matter,
.... **Do I**?

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A Journal on Innovation and Best Practices in Aboriginal Child Welfare Administration, Research, Policy & Practice
Volume 4, Number 1, 2009, pp. 10-19

Going Back to the Roots: Using the Medicine Wheel in the Healing Process

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Abstract

This article describes *Building A Nation*, a store front program located in the heart of the core neighbourhood (west side) of Saskatoon and its use of the Medicine Wheel in providing a blend of traditional and western support services including supportive therapy to those who come through its doors. This article begins with a discussion of the need for culturally safe and competent counselling programs and how *Building A Nation* meets that need. Following this the paper discusses the Medicine Wheel and how the Medicine Wheel is used in the *Building A Nation* program. This article is a step toward completing the recommendation by the Aboriginal Healing Foundation that *Building A Nation* "provide more clarity about how western and traditional healing methods complement each other or blend together (Aboriginal Healing Foundation 2006, p. 275).

The Need for Culturally Safe and Competent Counselling Services

Writing about the effects of racism on mental health services in the United States and focusing on the Afro-American population, Rollock and Gordon (2000) state "As a belief and an action potential, racism can erode the mental health status of its individual victims and dominate the institutional and cultural mechanisms through which it operates" (p.6). They further go on to list the areas racism influences as the definition of mental health and pathology, the explanation of the etiology of mental health problems, their evaluation and treatment and the institutional structure in which metal health services are delivered, including the training of mental health professionals (p.6-7).

Cultural safety and cultural competence, which have been identified as key components in providing services to Aboriginal People (NAHO, 2009), are attempts to counter the influence of racism on mental health services. Cultural safety refers to the need to move "beyond the concept of cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization and colonial relationships as they apply to health care" (NAHO, p.3). Cultural competence is defined as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross cultural situations" (U.S. Department of Health and Human Services, 2007 cited in NAHO, 2009, p.3). The U.S. Department of Health also states that "the seven domains (of cultural competence) are: organizational values, governance, planning and monitoring/evaluation, communication, staff development, organizational infrastructure, and services/ interventions (U.S. Department of Health and Human Services, 2007, cited in NAHO, 2009, p.3).

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Research shows that the lack of cultural safety and cultural competence leads to problems such as incomplete assessments, incorrect diagnoses, inadequate or inappropriate treatment, failed therapeutic alliances, high rates of non-compliance, reluctance to visit mainstream health facilities even when service is needed, and feelings of fear, disrespect and alienation (Kirmayer, et. al., 2003, p. 153; NAHO, 2003, cited in NAHO 2009). According to some researchers (Sue, 1981; Trimble and Fleming, 1990; and More, 1985, all cited in McCormick, 1996) Aboriginal peoples tend not to use the mental health services provided by the mainstream culture, and of those who do, approximately half drop out after the first session.

In the context of the population served by *Building A Nation* (BAN) a culturally sensitive and competent mental health program requires, among other things, that service providers recognize the impact of residential schools and the other forms of cultural assimilation attempted by the dominant culture to deal with the "Indian problem" on Aboriginal People today.

McCormick (1996, p.163) reports that Aboriginal People experience the same mental health problems as do their non-Aboriginal neighbours. In addition he reports that rates of suicide, depression, substance abuse, and domestic violence may be significantly higher among aboriginal peoples. Recent statistics indicate that the suicide rate among Aboriginal People is twice that of the Canadian population (Government of Canada, 2006, cited in Kirmayer. et al. 2007, p.13). These statistics point out the need for a counselling program that is both accessible and acceptable to Aboriginal Persons needing assistance who will not be able to benefit from counselling approaches that are not grounded in aboriginal beliefs and culture.

One example of the lack if fit between Aboriginal people and counselling services that are not culturally safe and competent is the cultural differences in understanding the causes and solutions for mental health problems. Traditional western thinking viewed mental health issues as a form of individual illness to be "cured" by trained experts. The recipient of services was viewed as an object on which healing activities were done, rather than a partner in the healing process. While current thinking in western therapy has moved from that model to a more egalitarian one in which the client is the expert and the therapist facilitates the healing process, the perception still exists that western therapies are based on the doctor patient, medical model approach.

The mainstream approach to the provision of mental health services may also view the mental health issue as a single, isolated one, failing to place it in the context of the entire life of the client including his/her stage of development and place in the community. This linear, isolating approach to mental health is at odds with the traditional First Nations approach with its focus on the Medicine Wheel and the belief that physical and mental health are the result of leading a balanced life.

This article will show how one program, *Building A Nation*, strives to meet the needs of a population of marginalized people, mainly Aboriginal, living in inner city Saskatoon. The article will demonstrate how using the Medicine Wheel as an organizing tool achieves this goal.

Building A Nation

History and Development

Building A Nation Family Healing Centre, Inc. was registered as a non-profit organization in 1998 and has been funded by the Aboriginal Healing Foundation. Currently BAN is funded primarily by the Aboriginal Healing Foundation with additional funding from some other national sources. BAN receives no funding from either the provincial or municipal governments.

BAN was founded by Mr. Glen McCallum and Dr. Tom Hengen. Both men, one Aboriginal and one non-Aboriginal, were working independently in different Aboriginal communities, one urban and one rural. They met and developed a shared vision of developing a program to serve those who live in the core neighbourhood of Saskatoon; a neighbourhood that is under serviced to the point of being neglected; its residents live in conditions of poverty and its accompanying challenges literally a short walk from thriving downtown Saskatoon.

Saskatoon's core neighbourhood is largely populated by people who came to the city from reserves and small rural communities across Saskatchewan because of the lack of jobs and resources for children and families in those areas. They were in effect forced from their home communities because of poverty, depressed circumstances, and the lack of resources that accompanies those conditions. In spite of their hope, and the lifestyle promised by city life, when they arrived on the west side of Saskatoon they found themselves in circumstances much like those they sought to leave.

For those living on reserves this migration was made both possible and necessary by changes in Federal Indian Policy. Prior to 1952 persons living on reserve were allowed to leave the reserve only with the permission of the Indian Agent. They were also not allowed to conduct business transactions outside the reserve. Records kept by the Federation of Saskatchewan Indian Nations (FSIN) indicate that between the start date of urban migration in1952 and the early1960's the number of Aboriginal Persons incarcerated in Canada effectively doubled (Michael, H., personal communication, June 5th, 2009).

For many of those leaving reserves and small rural communities the move from reserve to city, spurred by both opportunity and necessity, was like moving to a foreign country. The reserves were under the jurisdiction of the Federal government and the west side of Saskatoon was under the jurisdiction of city and provincial governments which ultimately proved to be no more capable of seeing the condition of the Aboriginal population improve than the Federal government had been. Speaking of health care services Evans, Sookraj, Berg & The Okanagan Urban Aboriginal Health Research Collective (2006, cited in Kurtz, et. al., 2009, p.54) state "the provision of services for urban Aboriginal people is impeded by the continuing rural/reservation orientation of many Euro-Canadian and Aboriginal policy makers."

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While the core area is largely populated by Aboriginal people, McCallum and Hengen recognized that they were not the sole residents of the neighbourhood; thus if they were to develop a program that would meet the needs of the people in that area it would be necessary to offer a service that would respect differing cultural and spiritual orientations. It is estimated that 90% of those who currently use BAN are Aboriginal Persons. Most of the others come to BAN because they are a relationship with a person of Aboriginal descent (Tom Hengen, personal communication, March 5, 2009).

BAN is headed by a Board of Directors made up of First Nations (Cree and Saulteaux), Métis, Euro-Canadian, and mixed cultural background. The staff also reflects this cultural mix. All are dedicated to restoring "the traditional Aboriginal way of perceiving and responding to experience as a remedy against the deleterious effects of enforced cultural assimilation – social disorientation and cultural deprivation, both of which are known to be health-related jeopardy conditions" (*Building A Nation*, 1998, p.3). The board members acknowledge that they "had to learn to work out our differences and how to bridge the gap. When we formed our board we did not see eye to eye, but it worked. We learned about each other. We learned about each other's culture" (The Times Observer, cited in Aboriginal Healing Foundation, Volume 2, 2006, p. 272). This learning process has been a part of all aspects of the development of the BAN program.

While not all of those who work at BAN are of Aboriginal origin, all share the vision of the program and all have, or have developed, traditional environmental knowledge (TEK). TEK is defined as knowledge accumulated through

> *"Time spent living on the land. It encompasses all aspects of the environment –biophysical, economic, social, cultural, and spiritual – and sees humans as an intimate part of it, rather than as external observers or controllers. TEK is part of the collective memory of a community, and is passed on orally through songs and stories as well as through actions and observations." (Environment Canada, n .d. p. 1).*

In the case of BAN staff TEK include knowledge of the core city environment.

The mission statement of BAN reads:

> *"Build our Nation, Canada, as a community of citizens living in the spirit of a 'cultural mosaic' in harmony together. Our logo portrays this. Our company's structure, comprised of First Nations, Métis, and mainstream people demonstrates this. It is our purpose to honour real differences as gifts of diversity and to achieve harmony and integrity by commitment to common goals." (Building A Nation, 1998. p.2)*

The BAN logo is the creation of Gary Natomagan, a recognized Cree artist who grew up near Pinehouse Lake, Saskatchewan. The left side of the logo represents the Métis community, the right the First Nations of Canada. The name *Building A Nation* reflects how the goal of BAN, building a social nation, differs from the goals of the Canadian government, the Federation of Saskatchewan Indian Nations (FSIN) and the Métis Nation Society (MNS), all of which have stated goals of building political nations.

BAN program

In the funding application to the Aboriginal Healing Foundation the BAN program is described as follows:

> *"To provide clinical and traditional counselling services, as well as child custody, justice system, and social assistance program support to individuals and specific interest groups. Clinical services are provided by a registered counselling psychologist, a certified mental health therapist, whose practices are done in the four directions worldview, providing counselling to women, children, men and couples. Crisis services are provided by trained crisis intervention counsellors of Aboriginal descent. We have a traditional therapist who provides traditional ceremonies and practices as well as counselling to our clients and survivors. (Waldram, 2005, p.4)*

A subsequent application for renewed funding indicated a continuing commitment to this agenda with additional emphasis on dealing with issues related to Indian Residential School survivors.

The final report of the Aboriginal Healing Foundation indicates that "in addition to individual and group counselling, healing activities include traditional celebrations and ceremonies, continuing support (e.g. drop in center, client advocacy for those involved in the justice system, child custody) and social gatherings (Aboriginal Healing Foundation, 2006, p. 265). Client skill development programs have included programs titled "Aboriginal Parenting Skills," and "Aboriginal Counselling and Cultural Education Strategies and Systems (A.C.C.E.S.S.)." The counselling component of the youth program has

subsequently been offered as "Medicine Wheel Counselling and Case Management" at four levels of competency by the sister organization, *Building A Nation* Training Institute, Inc., a private vocational school registered with Saskatchewan Learning (the Saskatchewan government ministry responsible for education).

A ten week youth oriented theatre production program called "Circle of Voices" designed to actualize theatrical talent in young people and thus help in nation building by using the healing power of the arts to tell the story of their struggle towards healthy lifestyle in Canadian mainstream culture was offered. The 'Circle of Voices' initiative has developed into the very successful Saskatchewan Native Theatre Company which enhances the core neighbourhood with a live-stage theatre that regularly mounts productions, written, acted, produced, and directed by Aboriginal community members; serving both the core neighbourhood and the greater Saskatoon community while honouring their cultural heritage.

Provision of Service

The Aboriginal orientation of BAN is obvious when one is greeted by the scent of sweetgrass as one walks through the door. One client described how, when he entered BAN and smelled the sweetgrass, he felt relaxed. "It's hard to explain but when you come into a place with sweetgrass and the pictures (native art) on the walls it triggers something in you. … This is where you belong" (D. Michel, 2007, Personal communication).

The person staffing the front desk has knowledge of the support services available to most visitors as well as contact persons within the Saskatchewan Department of Community Resources, the city police, and medical services. Visitors are greeted in a pleasant, supportive manner while sufficient information is gathered to determine their needs. A client describes the importance of this initial contact this way "Its the atmosphere when you come in here, even the woman at the front desk, she smiles at you and talks to you nice" (D. Michel, 2007, Personal communication).

Clients of BAN can move beyond the waiting room into a common room where they can sit and visit with each other and the staff in a very informal way. An appointment is not needed to access this space nor is there any expectation that those in the room will seek further service while they are there. This common room serves as a safe place for those who need to retreat from life in the core neighbourhood and those who seek positive peer support. Clients can also wait in this area for their counsellor and can spend time there after visiting the counsellor.

As one counsellor put it "this is a safe area for now and sometimes they (clients) need safe areas. They can come in and be part of the family. So they are welcome" (C. Crevier, 2007, Personal communication). A client described using the common room to escape from his former friends; a group that included drug dealers, alcoholics and others living on the street: "It was more of a sanctuary. .. I'd say to my friends I'm gonna hang out there and meet people, meet different people. Now I know a lot of people and I know myself more" (D. Michel, 2007, Personal communication).

The counsellors at BAN are frequently described as "rented" uncles or aunts who respectfully walk with their clients during the changes that they must make in their lives.

Recipients of Services

Off-reserve communities are among the largest and fastest growing Aboriginal communities in Canada with over 70 per cent of Aboriginal people living in urban areas (Statistics Canada, 2006, cited in Kurtz, et. Al, 2009, p. 54). For the population served by BAN as well as for Aboriginal people across Canada and Indigenous Peoples around the world, colonial policies and practices have had a multigenerational impact. These policies and their sequelae have resulted in problems such as homelessness, addictions, poverty, domestic violence, family dysfunction, and a lower health status for many Aboriginal people. A recent study in Saskatoon measured the health differences in low and high income areas of the city and found residents of the poorer areas, of which the core neighbourhood was one, had statistically significantly higher incidences of suicide attempts, mental disorders, injuries and poisonings, diabetes, chronic obstructive pulmonary disease, coronary heart disease, chlamydia, gonorrhoea, hepatitis C, teen birth, low birth weight, infant mortality and all cause mortality (Lemstra, Neudorf, & Opondo, 2007). The inability of existing social services to meet this need highlights the need for the services offered by BAN.

While the BAN program has not produced detailed demographic information about those it serves, it is estimated that about 1,000 individual files are active every year. As these files are in the name of a single person the actual number of those served is significantly higher as usually nuclear and extended family members are also served (T. Hengen, Personal communication, May 28, 2009). Waldram, et. Al (2005) interviewed 18 participants of the BAN program and offered the following profile of clients:

- Mean age 41
- 72% male
- 78% single
- 61% caregivers for children in their home
- 44% spoke no aboriginal language
- 90% of those who spoke an aboriginal language spoke Cree

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- 76% had little or no knowledge of their aboriginal heritage
- 50% had attended residential school
- 61% had experienced foster care
- 72% had been adopted

While this profile was drawn from a small opportunistic sample it provides a picture of those who make use of the services BAN provides.

The final report of the Aboriginal Healing Foundation offers this description of the BAN clientele, based on a study of 432 clients:

- 70% had experienced physical abuse
- slightly less than 50% had suffered sexual abuse
- just over 30% had been incarcerated
- just over 20% were survivors of residential schools (Aboriginal Healing Foundation, Volume 2, 2006, p. 267).

While BAN is located in Saskatoon's core neighbourhood and the majority of its clients live in that area, the recipients of services come from throughout the city. As one counsellor pointed out, while the socioeconomic status may vary, the needs of all BAN clients are similar.

> *"We've also had educators, counsellors, health professionals in different areas that come here that are not on the street. They are out there. They are doing. They are educating children. They are helping. They are out there in society. They meet society's norms. ... but they have similar problems with sexual abuse, physical abuse, and this and that in their developmental years. They come here; they face the same problems with alcohol abuse, drug abuse all the same. ... The Medicine Wheel helps them see where they are as an individual person. So they have to express their desire to do something, they have to know what they want to do, they have to know who they are, they have to know what they came from in order to go on." (C. Crevier. 2007, Personal communication)*

Medicine Wheel

The Aboriginal world view is shaped by a sense of balance, interconnectedness, and transcendence (McCormick, 1996). A circular, rather than linear, way of thinking puts the focus of the world view on relationships and balance. From this perspective mental health can be understood as achieving a balance between the parts of the self - emotional, physical, mental and spiritual; finding one's place in relation to other human beings, finding one's place in relation to mother earth, and looking beyond oneself (Chansonneuve, 2007).

Montour, speaking from the twin perspectives of a person of Mohawk ancestry and a medical practitioner, says:

> *"The Medicine Wheel concept from Native American culture provides a model for who we are as individuals. We have an intellectual self, a spiritual self, an emotional self, and a physical self. Strength and balance in all quadrants of the Medicine Wheel can produce a strong, positive sense of wellbeing, whereas imbalance in one or more quadrants can cause symptoms of illness. Addressing issues of imbalance can potentially diminish your patient's symptoms and enrich their quality of life."* (Montour, 1996)

McCormick states "First Nations healing requires the individual to transcend the ego rather than strengthen it as Western counselling aims to do" (1996, p. 164). The Medicine Wheel represents this understanding to those who understand its meaning. The wheel represents both the connectedness and transcendence, while the four quadrants of the wheel represent the balance. The sense of community and transcendence also means that the Aboriginal person has the support of her/his community and is expected to provide support to others.

The use of the Medicine Wheel in this way is an example of holistic practice (Chansonneuve, 2007), a concept that in recent years had a strong influence on all forms of human services. Holistic practice can mean either an approach that takes into account the mental, physical, emotional, spiritual and social components of human functioning or as an umbrella term for alternative medical practice. In this article the former definition will be used.

While the holistic movement should be seen as having its roots in traditional Aboriginal teachings, within mainstream thought its roots come from the Social Work "person-in environment" paradigm which was rooted in the ecological and systems theories (Kemp, Whittaker, & Tracy, 1997). The Person-In Environment paradigm reached its peak with the 1994 publication of "Person-in Environment System: The PIE Classification System for Social Functioning Problems" (Karls & Wanderi, 1994). The PIE classification system with its focus on social functioning, environmental problems, mental health problems, and physical health problems (Karls & Wanderi, p. 24) was heralded as the social work alternative to the DSM diagnostic system. More recently it has resurfaced in the Social Work literature under the titles resiliency and relational perspectives (Van Hook, 2009).

The Medicine Wheel as Used at BAN

As Bruyere states, teachings based on the Medicine Wheel have been "used to inform a multiplicity of cultural practices since time immemorial" (2007, p. 259), even physical activity (Lavallee, 2009). As the philosophical

and therapeutic paradigm for BAN, the Medicine Wheel is used as "a pedagogical tool for helping clients understand, visually as well as conceptually, how to lead a balanced and healthy lifestyle" (Waldram, 2005, p. 22). The Medicine Wheel serves to anchor the BAN program to the values of the traditional Aboriginal worldview as well as serving as a paradigm with which to integrate mainstream theories and techniques. At BAN the Medicine Wheel is used in many ways, including to:

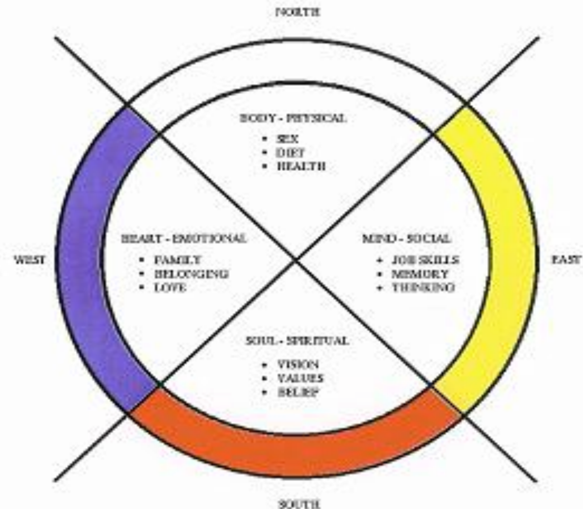
- Organize human experience: By teaching clients as adult learners the Medicine Wheel view of human development, clients take cognitive ownership over their personal histories and begin to make predictions and form growth goals for themselves.
- Track human growth: Notably the longer-term effect of remedial therapies indicated in the case plan.
- As a general assessment tool by which to organize the client's medical and psychological (developmental) history.
- As a tool designed specifically for trauma assessment: Specifically to chart the impact of untreated Post Traumatic Stress Disorder symptoms (DSMIV-TR APA2002, p.463 etseq.) particularly trauma symptom sets unique to the Aboriginal population (Wesley-Esquimaux & Smolewski, 2004).
- Decision making regarding the relative efficacy of remedial therapies.
- Psychological testing with a more relevant developmental {dynamic} view rather than a clinical snapshot or static view of the clients' condition.
- Case management: Organizing observable outcome target behaviours.

The version of the Medicine Wheel used at BAN is based on the Cree Medicine Wheel as persons of Cree background make up the largest percentage of the population in the neighbourhood being served as well as being the largest Aboriginal group in Saskatchewan.

World view

The worldview taught and modelled at BAN can best be described using the four directions of the Medicine Wheel:

- **The West**, childhood, springtime and emotional beginnings. It is represented by the beginning stage of learning and the earliest level of moral development, namely: Coercion/competition – authority or teacher-directed actions; the natural instinct to fill one's own needs is balanced by the need to comply with persons on whom one must depend (power/authority).



- **The North**, youth, summertime and physical maturity. It is represented by the next stage of learning from peers, and the next level of moral development which is: cooperation – peer directed actions; the natural instinct to develop one's own strengths leads to connecting with others who are close in age/stage to doing the same, as models of the next steps in development. Freedom requires and develops self reliance by gradual shifts from dependency to self-reliance.
- **The East**, adult, the time of harvest and mental maturity. It is represented by the next stage of learning as a self-directed learner, and the next level of moral development which is: Contribution – self directed actions.
- **The South**, elder, the time of spiritual maturity. It is represented by the last stage of learning as directed by one's values [the pipe and the medicine bundle] and the highest level of moral development which is: consecration – values-directed actions; giving completely (Hengen, 2006a, 2006b).

One counsellor describes the Medicine Wheel based approach to therapy in these terms:

> *They start filling in the four quadrants. They can see themselves as a whole person, what happened here (in childhood), what happened here (as a youth), that is happening here (as an adult), to make them who they are today. Then they say to themselves 'Well for this one I'm going to do this treatment or I'm gonna go to sweats, or go to a doctor or .... They know what it's about and they can see what it's about. Then the cultural content is really there for them to realize that this is who I am. I am still Native. I can be proud of*

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who I am.' ... So they begin to heal themselves.... We (the counsellors) validate and then support them in their journey. They're the ones who are working. We are just sort of leaning posts along the way, or the cane." (C. Crevier, 2007, Personal communication)

Animal Imagery

A BAN counsellor described using a Medicine Wheel filled with animal images.

> *"When we look at the eagle in the Medicine Wheel down here (south quadrant) because the eagle's way up there (pointing toward the ceiling) and he's got the whole view of what's down there and this is what, if we had that sort of view and look down on ourselves to see what all of our problems are and what we need to do about the healing process.*
>
> *And then if you look at the bear (West quadrant), the emotional aspect. The bear protects her cubs. They are a ferocious animal when you try to take their cubs away from them. And if our parents were like the bear way back when there's no way we'd had residential schools. There was no way they'd of let us go there. ...*
>
> *And we look at the buffalo (north quadrant). They're powerful animals. They were necessary for our survival, they gave us our life.*
>
> *And when you look at the wolf (east quadrant) and how the wolf works in packs just like our men did in hunting. They worked in packs and they shared their kill. When the men came back from hunting it wasn't only the one who killed the deer who had the deer, it was shared with the whole camp. So my understanding of the Medicine Wheel concept is it is a holistic approach. It talks to the whole person." (F. Badger. 2007. Personal communication)*

Organizing Human Experience

BAN offers a training program for its staff in the use of the Medicine Wheel. In the training literature the quadrants of the Medicine Wheel are used to organize human experience, specifically the four major factors thereof, which become the template for identifying types of needs and types of healing and helping services:

"The major factors of human experience included in the Medicine Wheel are:

- ***Emotional factors***: these include the array of human feelings, of love, belonging, fear, joy and the like. Issues that began in childhood are often located in this quadrant as well.
- ***Physical factors***: these include diet, health, sexual identity and maturity. Issues of addiction, chronic or acute stress symptoms and developmental issues of adolescence are placed in this quadrant.
- ***Mental/social factors***: general intellectual ability, social skills, education, career development and interpersonal communication are included as mental abilities. Issues of spousal relationships, parenting, liaison with service and Crown agencies and adult education are generally placed in this quadrant.
- ***Spiritual/moral factors***: moral values, respect, religious beliefs, and personal goals are included as matters of the spirit; spiritual or moral development is often plotted in this quadrant as the inventory of what the client respects enough to actually pursue as goals related to items in their 'respect' inventory." (Hengen, 2006a, p. 2)

Human Growth

Human growth can also be symbolized using the Medicine Wheel. In the BAN training manual this aspect of the Medicine Wheel is organized in this way:

- ***Childhood***: the time when emotional conditions are developed and established within the person. This is called the spring-time of life; it is the start of growth toward full human experience. Healthy emotional bonding, learned by experience during childhood, is the foundation for good parenting in later life.
- ***Adolescence***: the time when physical conditions are developed and established within the person. This is called the summer of life, the season of rapid physical growth; the body becomes mature during adolescence and the strengths or potentials for productivity are manifested. Acquiring impulse control is the key feature of adolescent development.
- ***Adult***: the time of mental and social maturity. Education is completed or extended and careers are developed. This is the season of harvest that runs from early life to late in life, as does the need for hunting and gathering, or meaningful work for most persons, particularly those with large extended families. Besides emotional bonding, parenting skill is composed of a strong sense of what is socially healthy for children and families.
- ***Elder***: the time of spiritual maturity. Completion of the human life cycle is realized by the fulfillment of goals and personal values lived out to some sense of completion. This is the winter of life when the person prepares to return to the earth mother for rest. The transmission of cultural traditions is one of the personal and family duties of elders. Presenting the model of personal integrity is one of the social responsibilities of elders (Hengen, 2006a, p. 2-3).

The Medicine Wheel As An Assessment Tool

As stated earlier, the Medicine Wheel is used at BAN both to anchor the program to the values of the traditional Aboriginal worldview and to serve as a paradigm with which to integrate traditional and mainstream theories and techniques. One non Aboriginal counsellor described her use of the Medicine Wheel as a step in making her work more culturally competent (Thomas, 2006).

Clients of Aboriginal background are greeted and served at BAN through a tool that represents a worldview different from that of the western culture around them. The Medicine Wheel is a "cultural traditional model that they accept and it doesn't have to be forced on them because they accept it naturally especially if they are First Nation, Métis (they say). Well, this is mine; this is where I come from so they accept it on those terms more than they would an assessment given by a professional because they don't know what's going on there" (C. Crevier, 2007, Personal communication).

Psychological Testing

As indicated in the description of the services offered by BAN, psychological testing is used to assess clients for things like mental health, intelligence, and parenting capacity. The holistic understanding of human nature imbedded in the Medicine Wheel is not always compatible with the protocol of a psychological assessment and the type of reporting required by child welfare and the justice system to make their decisions. Dr. Hengen, a registered psychologist, combines the training and needs of the western establishment with the teachings of the Medicine Wheel by reporting on the test instruments he uses, their purpose and limitations and their findings within the holistic perspective of the Medicine Wheel by interpreting the test results within the socio-cultural context the clients find themselves.

The use of the Medicine Wheel as a of reference for taking case history and framing diagnoses on DSM-IV access one and associating reliable remedies and curative procedures mapping against such diagnoses insures that cultural differences are less likely to be misinterpreted as psychological deviances. As mentioned earlier in this paper, this lack of culturally sensitive diagnosis is argued to contribute to the over diagnosis of pathological conditions in Aboriginal People.

One of the counsellors (C. Crevier, 2007, personal communication) and the client (D. Michel, 2007, personal communication) interviewed for this paper suggested another difference in the way psychological testing is done at BAN as opposed to at mainstream psychological centres. They both talked about how counsellors in other centres didn't look at clients, didn't understand them and said things to the clients that the clients did not understand. The BAN approach, based on the Medicine Wheel and respect for clients, removes, or at least reduces, this professional barrier while maintaining the quality of the psychological assessment and increasing its interpretative value.

Assessment of Trauma

In the second level of training BAN counsellors are taught that the Medicine Wheel can be used as an assessment tool to "harvest information about the client, especially about trauma or injury (instability) can be detected in matters of: the heart, the body, the head and the spirit. Each dimension has its own symptoms of injury or need for medicine:

- ***the heart (emotional)***: gets overloaded with strong feelings coming all at once; pain leads to fear, which leads to anger, which leads to hostility, which leads to guilt, which leads to more pain.
- ***the body (physical)***: gets both tired and edgy, over-sensitive to noise and touch and light, but numb to comfort; diet changes, usually not for the better; stress is more physical than people realize.
- ***the head (mental)***: gets confused when stressful or crisis events occur; concentration is difficult, memory is lost, distractions happen easily; relationships suffer; social isolation and withdrawal (wounded go off and hide); thinking shuts down to a few automatic (knee-jerk) reactions/habits; defensiveness takes over – blaming, denying, projecting, avoiding, rationalizing the soul (spiritual): what a person respects is key to their spirit; the spirit that guides a person's life can be seen in the way they act more than in the way they talk (Hengen, 2006b, p. 16-18).

Decision Making

The Medicine Wheel is also used to organize the aspects of the decision making "executive control" functions of human behaviour.

- **Emotional self control**: directs and cues the use of feedback to strengthen, change and reduce or suppress emotional reactions.
- ***Motor self control***: directs the use of motor abilities to translate thought into action and create tangible products.
- ***Mental self control***: directs the selective getting, holding, manipulating, storing, and retrieving of information and action planning.
- ***Spirit (moral) self control***: directs the use of emotional, physical and mental processes to construct visions of the future and plans for action over longer periods of time; reflects on the past to improve the present (Hengen, 2006a, p. 20.).

Case Management

BAN counsellors are taught that the Medicine Wheel as a case management tool which includes:

1. A chart or map of findings; problems or wounds in each area are identified; solutions and remedies (medicines) are found;
2. A plan is made to apply medicines to wounds for healing;
3. A plan which is managed by the client or learner, with help to learn how.

Counsellors are taught that they help create the plan, help to guide it at first, then turn it over to the client for maintenance by a series of steps that honour and support the process of adult learning (Hengen, 2006b, p.10).

Summary and Conclusions

The BAN program offers a significant service to Aboriginal and non Aboriginal persons living within and outside the core neighbourhood of Saskatoon. The Medicine Wheel is the key concept used and its use permeates the entire program. The Medicine Wheel provides a visual teaching and learning tool which ties the program and its participants to the traditional aboriginal worldview. Clients who leave the clinic with Medicine Wheel icon and its explanation report that they can use this knowledge to understand their thoughts and feelings between visits (Tom Hengen, personal communication, May 28, 2009). This helps them to develop and maintain a self directed lifestyle management plan.

Looking at the treatment process at BAN from a western social work perspective, BAN offers a culturally sensitive, supportive form of nondirective psychotherapy. Respect for the client, providing them a setting in which they can feel safe to face the issues they need to face, and providing them with the support they need to make changes are central to the service offered.

While the Medicine Wheel is a specific Aboriginal icon, it is presented at BAN as a learning and teaching tool rather than a religious or spiritual icon. Doing this makes it a tool that can be used by anyone who seeks services from the staff at BAN.

While many might know little or nothing of its meaning and significance, few people living in western Canada would not recognize the Medicine Wheel icon as a symbol of traditional Aboriginal culture. The values of living a balanced life and the clear visual representation of what that means provided by the Medicine Wheel is something that transcends cultures. For Aboriginal clients the Medicine Wheel provides the additional benefit of showing the importance and relevance of their traditional worldview, something that the euro-Canadian mainstream has been trying to denigrate and wipe out for over 100 years.

References

Aboriginal Healing Foundation. (2006). *Final Report of the Aboriginal Healing Foundation: Volume two: Measuring Progress: Program Evaluation*. Ottawa Ontario. Aboriginal Healing Foundation.

Building A Nation. (1998). *Building A Nation – **prospectus***. Unpublished manuscript

Bruyere (2007). Making circles: Renewing first nations ways of helping. In Coates, J.; Graham, J.; Swartzentruber, B. with Ouellette, B. ***Spirituality and Social Work: Selected Canadian Readings,*** p 259-272. Toronto. Canadian Scholars Press.

Chansonneuve, D. (2007). ***Addictive Behaviours Among Aboriginal People in Canada***. Ottawa. Aboriginal Healing Foundation.

Environment Canada. *Aboriginal Traditional Knowledge and Environmental Management*. Retrieved 20/07/2006 from http://www.wc.gc.ca/science/sandsept-02/printversion/print1_e.html.

Wesley-Esquimaux, CV. & Smolewski, M. (2004). *Historic Trauma and Aboriginal Healing*. Ottawa. Aboriginal Healing Foundation.

Hengen, T. (2006a). *Medicine Wheel Counselling and Case Management Training Package. Level 1. Building A Nation* Training Institute.

Hengen, T. (2006b). *Medicine Wheel Counselling and Case Management Training Package. Level 2. Building A Nation* Training Institute.

Kemp. S.; Whittaker, J.; & Tracy, E. (1997). *Person-Environment Practice: The Social Ecology of Interpersonal Helping*. Hawthorne, New York, Aldine De Gruyter, Inc.

Karls, J. & Wanderi, K. (1994). P*erson-In-Environment System: The PIE classification System for Social Functioning Problems*. Washington, D.C., National Association of Social Workers Press

Kirmayer, L.; Groleau, D.; Jaswant, J.; Blake, C.; & Jarvis, E. (2003). Cultural consultation: A model of mental health service for multicultural societies. *Canadian Journal of Psychiatry*, 48(3), p. 145-153.

Kurtz, D., Nyberg, J., Van Den Tillaart, S., Mills, B. and The Okanagan Urban Aboriginal Health Research Collective (OUAHRC). (2009). Silencing of voice: An act of structural violence. Urban aboriginal women speak out about their experiences with health care. *Journal of Aboriginal Health* 4(1), p.55-63.

Lavallee, L (2009). Balancing the medicine wheel through physical activity. *Journal of Aboriginal Health*, 4(1), p.64-71.

Lemstra, M.; Neudorf, C. &Opondo. (2006). *Health Disparity By Neighbourhood Income*. Saskatoon Health District.

McCormick, R. (1966). Culturally appropriate means and ends of counselling as described by the First Nations people in British Columbia. *International Journal for the Advancement of Counselling*, 18, p.163-172.

Montour, L. (1996). *The Medicine Wheel: Understanding "Problem" Patients in Primary Care*. Presented at the fifth annual meeting of the Native Physician Association in Canada. Ottawa, Ontario, August 23-25, 19956. Retrieved February 4, 2007 from http://xnet.kp.org/pemanentejournal/winter00pj/wheel.html.

National Aboriginal Health Organization (2009). *Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educator*. Retrieved May 29, 2009 from http://www.naho.ca/publications/culturalCompetency.pdf.

Rollock, D. & Gordon, E. (2000). Racism and mental health into the 21st century: Perspectives and parameters. *American Journal of Orthopsychiatry*, 70(1), p.5-13.

Thomas, R. (2006). *Collecting stories, collecting culture: An integrated practicum report from a Building A Nation practicum January – June, 2006*. Unpublished monograph, University of Regina Faculty of Social Work.

Van Hook, M. (2009). *Social Work Practice with Families: A Resiliency Based Approach*. Chicago IL, Lyceum Books Inc.

Waldram, J.; Innes, R.; Kaweski, M.; & Redman, C. (2005) *Building A Nation Inc.; A Models and Metaphors Research Project Case Study, Final Report*. Ottawa Ontario. The National Network for Aboriginal Mental Health Research and Training.

First Peoples Child & Family Review
A Journal on Innovation and Best Practices in Aboriginal Child Welfare Administration, Research, Policy & Practice

Volume 4, Number 1, 2009, pp. 20-27

Mental Health Promotion as a Prevention and Healing Tool for Issues of Youth Suicide in Canadian Aboriginal Communities

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Abstract

This article discusses the appropriateness of using mental health promotion as a prevention and healing tool for Canadian Aboriginal youth dealing with issues of suicide. Strengths of mental health promotion in the context of this population include its emphasis on community-wide approaches, consideration of root causes of mental health issues, recognition of culture as a protective factor, and integration of diverse forms of knowledge. Limitations include an inadequate role for spirituality, lack of culturally-sensitive program evaluation, and emphasis on Western patterns of time, space, and communication. In response to this analysis, recommendations are proposed that could guide the development of future mental health promotion programs.

Introduction

In Western society, the concept of mental health is often based on the assumption that reducing the number of cases of mental illness will result in a mentally healthier population (Keyes, 2007). Embedded within this assumption is an extremely important, but fundamentally flawed, hypothesis: the absence of mental illness is the presence of mental health. This hypothesis has been questioned for several reasons, not least of which is that the distinctions between mental disorders, as outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM 1V), can be ambiguous and arbitrary. Some scholars even question whether mental illness can exist as an objective physiological malfunction (MacDonald, 1999). If the criteria used to define mental illness are unclear, then it becomes inappropriate to classify mental health as the absence of mental illness. Moreover, only a small proportion of individuals otherwise free of a common mental illness actually experience high levels of mental wellbeing (Keyes, 2007). Focusing solely on mental illness will therefore have no positive bearing on promoting mental health.

As marginalized segments of Canada's population feel increasingly disenfranchised from this traditional view of mental health, new conceptions and approaches are slowly gaining respect. One such approach is the theory of mental health promotion. This theory posits that people have an intrinsic capacity to cope with and enjoy life, even if it is not evident at a given moment. In the context of supportive environments that provide access to health-determining resources, people are best able to decide what they want out of life and what is required to bring about those ends (Joubert & Raeburn, 1998).

The objective of this article is to examine the appropriateness of mental health promotion as a prevention and healing tool for Canadian Aboriginal youth who have experienced suicidal ideation or have attempted suicide in the past. By placing traditional healers and community members at the centre of the healing process, with Western practitioners as secondary helpers to these traditional healers, mental health promotion has the potential for offering a culturally-sensitive approach to healing that can be integrated into a diverse range of Canadian Aboriginal communities. This article will discuss the theory of mental health promotion and its intersection with the issue of youth suicide in Aboriginal communities. This will be followed by a discussion of the strengths and limitations of mental health promotion in the context of this population. It will then conclude with recommendations and guidelines that merit consideration when developing mental health promotion programs targeting youth suicide in Canadian Aboriginal communities.

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Theory of Mental Health Promotion

Although many definitions of mental health promotion exist in the literature, arbitrary definitions tend to leave a number of assumptions and values unquestioned, focus too heavily on individual-level factors compared to the social context, and do not adequately allow for the complex and subjective nature of mental health promotion (MacDonald, 1999). Instead, a variety of literature sources should be combined to provide a suitable and comprehensive understanding of a theory.

Mental health promotion can be identified at the micro, meso, and macro levels of society. At the micro level, health promotion efforts are aimed at improving an individual's resiliency, which is a quality that allows people to function well despite negative odds (Pape & Galipealt, 2002). Resiliency is supported by protective factors, which buffer a person in the face of adversity; and hindered by risk factors, which increase a person's susceptibility to poor mental health. Protective factors include social skills, support from peers and family, positive school climate, and sense of belonging, while risk factors can be described as insecure attachment, family violence, negative life events, poverty, and community instability (Centre for Addiction and Mental Health, 2009).

To achieve resiliency, protective factors must be facilitated through supportive environments (Pollett, 2007). The support of family, peer groups, workplaces, and communities comprise the meso level of mental health promotion. This level assumes that if people have access to relevant, usable, and supportive resources that are tailored to their needs, culture, and stage of life, then they can collectively engage in a process of empowerment and recovery (Joubert & Raeburn, 1998). Implicit in the meso level is the idea that mental health promotion should direct its efforts toward the community as a whole, as communities establish norms that direct behaviour and provide social support that help people cope with challenging situations (Kirmayer, Boothroyd, Laliberte, & Simpson, 1999).

The macro level focuses on the wider systems that govern and shape many aspects of our lives, including the social determinants of health and government institutions. This level is concerned with the enactment of social justice into policy and law (MacDonald, 1999). It necessitates addressing the root causes of poor mental health, which include income and social status, available mental health services, social support networks, education, physical environments, biology, childhood development, employment opportunities, and culture (Pape & Galipealt, 2002).

A model of mental health promotion developed by MacDonald and O'Hara (1996) is helpful in explaining the theory in the context of this article, as it accounts for elements at all three levels of society (micro, meso, and macro). According to this model, mental health can be promoted by helping all people, regardless of their mental health status, find ways of participating in society, developing their personal self-management skills, cultivating their abilities to acknowledge and work with their emotions, enhancing or repairing self-esteem, and improving the quality of the environments in which they reside. There is also a need to diminish alienation and exclusion; reduce stress that people experience; and challenge all acts of emotional abuse, negligence, and environmental deprivation. This model appears to suggest that each factor can be enhanced or demoted at the micro, meso, and macro levels. It fails to differentiate, however, between the strategies that would be employed at each particular level to bring about positive ends. Despite this limitation, the model acknowledges both promoting and demoting elements of mental health, does not attempt to over-simplify a complex issue, and remains culturally sensitive in that what counts as exploitation, social support, and environmental quality are left open to cultural and social interpretation (MacDonald, 1999). This cultural sensitivity is extremely important in the context of Canadian Aboriginal society.

Target Population

The term "Aboriginal" is used throughout this article for its inclusive properties, as it can describe Native, Métis, Indian, or First Nations people in Canada (McCormick, 2005). Aboriginal youth living in Canada are faced with conflicting messages. On one hand, they are influenced by a traditional worldview that shapes their belief system, assumptions, and modes of problem solving. Although this worldview varies according to tribe, level of acculturation, and other personal characteristics, there are some commonalities such as the relationship between people and the land, wholeness, spirituality, and a sense of collectiveness that can be used to identify the Canadian Aboriginal perspective (France, 1997). Consistent with this worldview is the idea that all things are interrelated. According to McCormick (1996), "interconnectedness can be viewed as the individual's connection to the world outside the self. Practically, this means to become connected or reconnected to friends, family, community, and culture" (p. 168). Since all things are interrelated, wellbeing is based on ensuring that one is in harmony with one's surroundings. When a person's physical, mental, emotional, or spiritual wellbeing is out of balance, illness is believed to ensue (Smye & Mussell, 2001).

This worldview is in stark contrast to the images of global youth culture that Aboriginal young people encounter in their daily lives or through mass media. These images reveal youth enjoying freedom, material wealth, and excess consumption (Kirmayer et al., 1999). Such images are not

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only inconsistent with the Aboriginal worldview, but they also conflict with the daily realities that some Aboriginal youth face. The effects of being physically, emotionally, culturally, and spiritually mistreated by European settlers and the Canadian government have profoundly affected the psyche of Aboriginal people to this day (France, McCormick, & Rodriguez, 2004). In many Native communities, this cultural oppression has resulted in economic uncertainty, limited job opportunities, and few positive expectations of youth for the future (Kirmayer et al., 1999).

These conflicting messages have led many Aboriginal youth to experience an identity crisis. Although this crisis of identity is amplified in Aboriginal communities – at rates three to six times higher than the general population – it is a fact of life shared by many young people regardless of their culture or ethnic background (Health Canada, 2002; Kirmayer, Simpson, & Cargo, 2003). According to Erik Erikson's Psychological Stages of Development, youth between the ages of thirteen and nineteen are exploring their independence and developing a sense of self. Some youth experience an identity crisis and use peers to reflect their identity back to them. If they resolve the crisis, youth will emerge from this stage with a strong sense of self and feelings of independence and control. If they fail to resolve the crisis, youth will remain insecure and confused about their role in society and their future (Health Canada, 2002). This confusion, coupled with a potential loss of valued relationships, interpersonal conflict, and perceived pressure for high scholastic achievement can be overwhelming. Many young people feel that the world does not respond to what they have to offer or that they lack the competencies to fulfill the world's expectations and requirements (Joubert & Raeburn, 1998). If one believes himself or herself to be a failure, then feelings of worthlessness and hopelessness are likely to result. Youth within Aboriginal communities may find it especially challenging to emerge from Erikson's stage of development with a strong sense of self, as they are often torn between two worlds; the world of their traditional, indigenous values and the modern, pervasive world of youth culture depicted in the media (Health Canada, 2002). Indeed, when the Canadian Institute of Child Health (2000) compared First Nations and non-First Nations suicide rates from 1989-2003 for 15-24 year olds, it found that the rate of suicide among First Nations young people was significantly higher than the national average. Among First Nations men between the ages of 15-24, the suicide rate was 126 per 100,000, compared to 24 per 100,000 for Canadian men of the same age group. Young women from First Nations registered a rate of 35 per 100,000 versus only 5 per 100,000 for Canadian women. Mental health promotion, with its emphasis on inner strength, supportive environments, and latent resiliency, can be seen as an appropriate prevention and healing tool for addressing the internal conflict that underlies much of youth suicide in Aboriginal communities.

Strengths of Mental Health Promotion

One of the most profound strengths of mental health promotion is its emphasis on the entire community. In the context of this theory, community refers to people united through social bonds, common interest, or locality (Joubert & Raeburn, 1998). Traditionally, Aboriginal people have practised informal helping by reaching out to their families, friends, and neighbours in times of need (France et al., 2004). This implies a long tradition of treating everyone in the community with respect, support, and dignity, and indicates that taking a community-wide approach to the prevention and treatment of youth suicide would be perceived as customary for many Aboriginal people. France (1997) further explains that the goal of healing in Aboriginal communities is not to strengthen a person's ego, but rather to encourage that person to transcend the ego by considering oneself as embedded in and expressive of the community. This can be accomplished through traditional ceremonies, such as the Vision Quest, which is a method of opening oneself to the spirit world by isolating oneself in the wilderness; and the Sweat Lodge, which is a method of purification that demonstrates respect to Mother Earth and all creation (France, 1997). These traditional ceremonies reinforce the importance of keeping family and community networks strong and can be integrated into a community-wide program aimed at healing Aboriginal youth. Another advantage of a community-wide approach is its capacity to avoid stigmatizing certain youth as suicidal within the community. Stigma can impact a youth's ability to access employment, education, and community activities (Pape & Galipealt, 2002). Programs that focus on the entire community can help marginalized individuals, such as youth struggling with suicidal ideation or past suicide attempts, to become better integrated into the community, and may even play a role in gradually shifting commonly held negative attitudes about youth suicide among members of the community.

The Community-Based Suicide Prevention Program in Alaska provides an example of the benefits that can be achieved when using a community-wide approach for Aboriginal youth suicide prevention. Developed and implemented by Alaskan Native communities, this program is unique in that local indigenous planning groups were required to form within each community to determine the needs of the community and oversee program activities before the program could be executed. Many aspects of this program focus on traditional activities that promote cultural values, such as elder and youth exchanges, where elders share traditional knowledge and wisdom with younger generations (Kirmayer et al., 1999). A program

evaluation conducted between 1989 and 1993 revealed that this project began in communities with higher suicide rates than the overall rate for Alaskan Natives, but at the end of three years, rates in project communities declined faster than state-wide Alaskan Native rates (Kirmayer et al., 1999). This evidence supports the notion that the strength of social bonds in many Aboriginal communities and the willingness to act for the benefit of the group provides a social support network in which community-based mental health promotion programs can flourish.

A second strength of mental health promotion is its explicit focus on the root causes of mental health issues. According to MacDonald (1999), many of life's ups and downs are not inevitable, but rather socially constructed. These instabilities are the result of social injustices, inequities, and health-demoting policies. The World Health Organization (2007) further explains that substance abuse, violence, and feelings of depression are more prevalent and difficult to cope with in conditions of high unemployment, low-income, limited education, stressful working conditions, gender discrimination, social exclusion, and human rights violations. This indicates that to successfully prevent youth suicide, one must focus on the underlying factors that contribute to feelings of depression in the first place.

This approach may be extremely relevant for Canadian Aboriginal youth, who continue to experience intergenerational trauma, poverty, unemployment, and inadequate housing in their daily lives (Smye & Mussell, 2001). Much of these unhealthy living conditions can be traced back to the impact of European colonialism. Early missionary activities focused on forced religious conversion by suppressing existing Aboriginal practices that were integral to their subsistence (Kirmayer et al., 2003). This placed many Aboriginal communities in a state of poverty and highly reliant on charitable and emergency food relief, which is not compatible with human dignity or good health. The later apprehension of Aboriginal children from the family, community, and cultural context via the residential school system and forced adoption into non-Aboriginal families has resulted in problems of identity and self-esteem for individuals growing up in unfamiliar and hostile conditions (Kirmayer et al., 2003). Experiences of physical and sexual abuse, emotional neglect, internalized racism, language loss, and suicide have been passed down through generations, and still affect Canadian Aboriginal youth to this day (Kirmayer et al., 2003). Transgenerational effects include the transmission of explicit models of parenting based on experiences in punitive institutional settings; patterns of emotional responding that reflect a lack of warmth and intimacy in childhood; and a loss of knowledge, language, and tradition that has led to the systematic devaluing of Aboriginal identity (Kirmayer et al., 2003; Shepard, O'Neill, & Guenette, 2006; Wilson, 2004).

Given this profound history of cultural oppression, programs endeavouring to heal Aboriginal youth who have experienced suicide ideation or attempted suicide in the past must address the root causes of their psychological pain. For example, programs could improve access to safe, affordable, and secure housing in ways congruent with the community and family orientation of many Aboriginal people. Research suggests that housing is one of the most salient considerations in mental health planning, as those unable to access appropriate housing have significantly reduced quality of life (Smye & Mussell, 2000). Regrettably, 25 percent of Canadian Aboriginal people living in metropolitan areas in 2001 experienced inadequate, unsuitable, and unaffordable housing, compared to only 13.5 percent of non-Aboriginal households (Canada Mortgage Housing Corporation, 2004). The Urban Native Housing Program (UNHP), delivered by the Canada Mortgage and Housing Corporation, grew out of a recognized need for culturally appropriate social housing for Aboriginal people coming from rural or reserve communities to urban areas. All units of housing developed under the UNHP were administered by local Aboriginal housing organizations and overseen by boards of directors and staff comprised mainly of Aboriginal people. Counsellors were also available to help tenants adjust to their new home environment. An evaluation of urban social housing programs in Canada found that a significantly higher proportion of Aboriginal tenants in UNHP had improved access to social services, had made more friends and felt more secure, settled, and independent compared to Aboriginal tenants in mainstream social housing (Walker, 2009). Despite this important piece of evidence, there has been virtually no research conducted on the emotional and psychological benefits of providing housing to Aboriginal peoples using culturally meaningful approaches (Mussell, Cardiff, & White, 2004). This indicates that very little has been done to address the relationship between housing and wellbeing, and exposes a worthwhile target for future mental health promotion planning.

A key goal of mental health promotion is to enhance protective factors as a way of moderating the impact of negative life events on social and emotional wellbeing (Centre for Addiction and Mental Health, 2009). Recognizing and valuing culture as an essential protective factor in this process is a third strength of mental health promotion in the context of Aboriginal society. McCormick (2000) acknowledges that to be disconnected from cultural values is to be disconnected from potential sources of meaning. This disconnect from traditional values was a deliberate strategy used by churches and the government of Canada in an attempt to assimilate Aboriginal people into Western culture. Prior to colonization, adolescence was not viewed as a distinct period in the life cycle between childhood and adulthood. Rather, young people in Aboriginal communities functioned as adults with responsibilities for subsistence

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activities and raising families (Kirmayer et al., 2003). With colonialism, the socialization of youth changed their role from a responsible member of the community to a passive recipient. Youth were largely excluded from community decision-making and left without clearly defined direction (Kirmayer et al., 2003).

Evidence suggests that disconnect from traditional culture is associated with high rates of suicide. A study conducted by Chandler and Lalonde (1998) rated Aboriginal communities in British Columbia on seven measures of cultural continuity. These included: 1) self-government; 2) involvement in land claims; 3) band control of education; 4) health services; 5) cultural facilities; 6) police; and 7) fire services. Communities with all seven factors had extremely low suicide rates, while those with none of the factors had extremely high rates. This indicates that not all Aboriginal communities are affected by suicide to the same extent. Communities that have taken active steps to preserve and rehabilitate their own culture are those in which youth suicide rates are lowest.

Mental health promotion, with its emphasis on participatory decision making and personal and collective empowerment, may represent an opportunity to re-integrate traditional healing practices into the lives of Aboriginal youth who have experienced suicidal ideation or have attempted suicide in the past. Knowledge of living on the land, community connectedness, and historical consciousness all provide sources of resiliency, where youth are better able to cope with significant adversity in positive and healthy ways (Kirmayer et al., 2003). An example of cultural and spiritual revival as a tool for healing can be found in Alkali Lake, British Columbia. This Aboriginal community used traditional healers to help its members revive time-honoured dances, ceremonies, and spiritual practices, such as pow-wows, sweetgrass ceremonies, sweat lodges, and drumming circles. The guiding philosophy of this treatment program was: "culture is treatment, and all healing is spiritual". Within ten years of initiating this cultural revival, alcohol consumption within the community decreased from 95% to 5% (McCormick, 2000). In this case, recuperating lost traditions reconnected Aboriginal people to their historical roots and mobilized practices to promote community solidarity. These are critical goals of mental health promotion, as cohesive, vibrant communities can provide the social support necessary to overcome challenging life events and promote positive mental health.

The emphasis that mental health promotion places on understanding health from multiple perspectives and adopting an intersectoral approach can be seen as a final strength in its relation to Aboriginal youth. Health promotion, which is the larger discipline of which mental health promotion is a part, defines health as a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity (World Health Organization, 1986). This definition implies that the prerequisites and prospects for health cannot be ensured by the medical sector alone. Indeed, mental health promotion programs are based on many sources of knowledge other than clinical, such as social science, experiential, customary, and traditional (Pape & Galipealt, 2002). Using these different approaches in an integrated and balanced way is consistent with aspects of the Canadian Aboriginal worldview. This view asserts that one part of a person cannot be central, but must instead learn to work in harmony with all other parts. This sense of balance is seen as necessary because the world itself is in balance among transcendental forces, human beings, and the natural environment (France, 1997).

By respecting diverse sources of knowledge and incorporating them into practice in a balanced manner, mental health promotion can demonstrate to Aboriginal youth that one aspect of a person's life should not supersede all other parts. Interpersonal relationships, difficulties in school, conflict with authority figures, and low-self esteem can feel overwhelming during adolescence, and consequently eclipse other enjoyable parts of life. Mental health promotion, in accordance with the Aboriginal worldview, would encourage youth to view their lives on more holistic terms and find balance in thoughts, feelings, and actions (France et al., 2004).

An example of a mental health promotion program that employs an integrated approach to healing is the Miyupimaatisiiuwin Wellness Curriculum offered by Cree Public Health in Montreal, Quebec. This school-based curriculum is dedicated to taking a holistic and comprehensive approach by covering a wide range of wellness issues. The program focuses on "wellness" because this term includes physical, mental, and spiritual health. All programming within the Miyupimaatisiiuwin curriculum is offered in an integrated manner. The curriculum is designed for students in kindergarten through to grade eight, but also reaches parents through a planned parental informed consent component built into each lesson. Relevant issues are extended and developed through the grades in a spiral manner with issues reappearing at each level in a more complex form (Kirmayer et al., 1999). By ensuring that all aspects of the program are interconnected, the Miyupimaatisiiuwin curriculum is congruent with the Aboriginal belief that wellbeing ensues when one is in harmony with his or her surroundings (France et al., 2004).

As the aforementioned discussion suggests, mental health promotion is a valuable theory to draw upon when developing prevention or healing programs for youth suicide in Aboriginal communities. There are, however, some features of this theory that limit its applicability in the Canadian Aboriginal context.

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Limitations of Mental Health Promotion

Mental health promotion can be adopted differently depending on its context, but very few discussions of mental health promotion recognize spirituality as an important dimension. For instance, the conceptual model of mental health promotion discussed in an earlier section of this article, is one of the most comprehensive models available, and yet still does not account for spirituality. MacDonald (1999), one of the authors of this model, acknowledges his apparent oversight by saying, “There has been some recent criticism that the map has no spiritual dimension, except for what might be included in the emotional processing element...My own bearing witness to this issue in our culture comes up with contradictory observations. And so, overall, we think that in our culture and at this time there are ten elements involved in mental health [not including spirituality]” (p. 41). The inability to recognize spirituality as a crucial dimension of wellbeing suggests that this model was designed for use predominantly in Western cultures. Indeed, many non-Native counselling approaches rarely deal with the spiritual aspects of people (McCormick, 1996). In contrast, spirituality plays a fundamental role in Canadian Aboriginal society and its use as a tool for healing would be unequivocal in most contexts. Spirituality can be described as getting beyond the self in order to connect with the rest of creation (McCormick, 2000). A study examining the development of a culturally sensitive framework for counselling with first Nations people determined that spirituality was one of the most important themes in the healing process for First Nations clients (McCormick, 1996). Ultimately, if mental health promotion is to be used effectively in the context of youth suicide in Canadian Aboriginal communities, then it must re-examine spirituality and transcendental ways of understanding the world.

A second limitation of mental health promotion is the lack of evaluation that has accompanied many programs and interventions. The fact that a program continues to exist is often taken as an indicator of its success. While this may be true, evaluation is an important component of program development, as it helps ensure optimal use of time and resources, determines if the program is meeting the needs of participants, and maintains accountability to stakeholder groups (The Health Communications Unit, 2007). There is an urgent need for research to evaluate suicide prevention and mental health promotion programs in terms of their effectiveness, feasibility, and wider social impact (Kirmayer et al., 1999). Health promotion, however, proceeds by small, incremental steps, with beneficial outcomes often considerably delayed (Health Canada, 1997). This indicates that health promotion can only be evaluated over an extremely long time frame, making it an unattractive feat for funders and practitioners alike.

Problems with evaluation are amplified in Canadian Aboriginal communities, as many Aboriginal people are distrustful of the research process due to unethical experiences throughout Canada’s history. Concerns include inadequate protection of individual and group identity, exposure to potential harms posed by research, involuntary participation, and stigmatization of individuals and communities as a result of negative research findings (Castellano, 2004). For mental health promotion to overcome these challenges, it must approach evaluation in Aboriginal communities with extreme care and caution. The Royal Commission on Aboriginal Peoples (2006) outlines a set of ethical guidelines for research in Aboriginal communities. These include establishing collaborative procedures to enable community representatives to participate in the planning, execution, and evaluation of research findings; ensuring that a representative cross-section of community experiences are included; distributing results of community research as widely as possible within participating communities; using non-technical and Aboriginal languages where appropriate; obtaining informed consent at all times; and incorporating perspectives on the subject of inquiry that are distinctly Aboriginal.

Even if mental health promotion was to acknowledge the importance of spirituality and adopt more culturally-sensitive evaluation methods, a fundamental limitation of this theory still remains. At its core, mental health promotion is predominantly a Western conceptualization based on Eurocentric notions of time, space, and communication. These conceptions bear a cultural orientation, set of values, theory of knowledge, highly specialized forms of language, and structures of power that are distinctly different from Aboriginal conceptions.

Western society has adopted a linear concept of time, which accepts that time is chronological and moving in one direction. Space is seen as consisting of parallel or elliptical lines, which has led to the emergence of disciplines such as geography, geometry, and physics (Janca & Bullen, 2003; Smith, 1999). In terms of communication, silence is negatively valued and has come to be interpreted as disrespectful and as a lack of understanding (Covarrubias, 2007). These distinctions are generally part of a taken-for-granted view of the world and are frequently used in both everyday and academic discourses. In contrast, the traditional Canadian Aboriginal worldview asserts that there are positions within time and space in which people and events are located, but these cannot necessarily be described as distinct categories of thought (Smith, 1999). In Aboriginal communities, lengthy periods of silence are customary in conversation and are used to listen to what is being communicated non-verbally (Covarrubias, 2007). This indigenous worldview has been undervalued and marginalized in Western society. For example, sacred spaces have been appropriated from Aboriginal peoples

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and then given back as controlled pockets of land known as reservations. Ideas about progress and time have led to portrayals of Aboriginal people as being lazy, devoid of strong work ethic, and possessing low attention spans. Traditional languages have been oppressed and replaced by European languages through the forced residential school system (Smith, 1999).

These conflicting notions of time, space and communication patterns not only pose challenges to the development and implementation of mental health promotion programs in Aboriginal communities, but they also contribute to the further colonization of Aboriginal peoples by applying a model that has a partial fit with indigenous worldviews. Space is needed where Aboriginal young people can address their own needs and priorities from a perspective that fully respects and incorporates traditional knowledge and epistemologies.

Summary and Conclusion

This article exposes some of the strengths and limitations involved in applying a predominantly Western theory of mental health to a population of Canadian Aboriginal youth who have experienced suicidal ideation or have attempted suicide in the past. On one hand, mental health promotion is relatively progressive and accommodating in its approach to mental health. By emphasizing community-wide approaches, addressing the root causes of mental health issues, acknowledging culture as an important protective factor, and balancing diverse forms of knowledge, this theory is highly consistent with many aspects of the Canadian Aboriginal worldview. On the other hand, mental health promotion does not adequately address spirituality, lacks culturally-sensitive modes of program evaluation, and focuses on Western patterns of time, space, and communication, which may inadvertently impose a colonizing framework. These limitations should not imply that mental health promotion would be an ineffective prevention or healing tool for Canadian Aboriginal youth who have experienced suicidal ideation or have attempted suicide in the past. Rather, they suggest the need for reflection and careful consideration when developing mental health promotion programs in any ethnic and culturally diverse community. Based on lessons learned from this analysis, mental health promotion programs targeting youth suicide should be addressed from biological, psychological, sociocultural, and spiritual perspectives; locally-initiated, owned, and accountable; responsible for the entire community; monitored and evaluated using appropriate methods and on an ongoing basis; rooted in Aboriginal culture; and facilitated in a manner that encourages participants to have a voice in program development, implementation, and evaluation. In addition to these considerations, mental health promotion teaches us that Canadian Aboriginal mental health issues cannot be effectively addressed unless they are part of a wider discourse that includes cultural identity, the natural environment, indigenous leadership, and socio-economic realities (Durie, 2004). After centuries of being viewed by the majority culture as disempowered, perhaps it is time to embrace a theory of mental health that focuses on the tremendous strengths of Aboriginal people.

References

Canada Mortgage Housing Corporation. (2004). *2001 Census Housing Series Issue 6: Revised Aboriginal Households*. Ottawa, Ontario: CMHC.

Canadian Institute of Child Development. (2000). *The Health of Canada's Children: A CICH Profile* (3rd Ed.). Ottawa, Ontario: CICD.

Castellano, M.B. (2004). Ethics of Aboriginal research. *Journal of Aboriginal Health*, 1(1), 98-114.

Centre for Addiction and Mental Health. (2009, January 16). Best practices guidelines for mental health promotion programs: Children & Youth. Retrieved February 29, 2009, from http://www.camh.net/About_CAMH/Health_Promotion/Community_Health_Promotion/Best_Practice_MHYouth/index.html.

Chandler, M.J. & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry*, 35(2), 191-219.

Covarrubias, P. (2007). (Un)biased in Western theory: generative silence in American Indian communication. *Communication Monographs*, 74(2), 265-271.

Durie, M. (2004, September). *Indigeneity, and the Promotion of Positive Mental Health*. Paper presented at the Third World Conference for the Promotion of Mental Health and Prevention of Mental and Behavioural Disorders.

France, H. (1997). First Nations: helping and learning in the Aboriginal community. *Guidance and Counselling*, 12(2), 3-8.

France, H., McCormick, R., & Rodriguez, C. (2004). The red road: culture, spirituality, and the sacred hoop. In C. Rodriguez, G. Hett & H. France (Eds.), *Diversity, Culture and Counselling: A Canadian Perspective* (pp. 265-281). Calgary, Alberta: Detselig Enterprises Ltd.

Health Canada. (1997). Health promotion in Canada – a case study. *Health Promotion International*, 13(1), 7-26.

Health Canada. (2002, October). *A Report on Mental Illnesses in Canada*. Ottawa, Ontario: Health Canada Editorial Board Mental Illnesses in Canada.

Janca, A. & Bullen, C. (2003). The Aboriginal concept of time and its mental health implications. *Australasian Psychiatry*, 11(S1), S40-S44.

Joubert, N. & Raeburn, J. (1998). Mental health promotion: people, power and passion. *International Journal of Mental Health Promotion*, 1, 15-22.

Keyes, C.L.M. (2007). Promoting and protecting mental health as flourishing. *American Psychologist*, 62(2), 95-108.

Kirmayer, L.J., Boothroyd, L.J., Laliberte, A., & Simpson, B.L. (1999). *Suicide Prevention and Mental Health Promotion in First Nations and Inuit Communities*. Montreal, Quebec: Culture and Mental Health Research Unit, Jewish General Hospital.

Kirmayer, L.J., Simpson, C., & Cargo, M. (2003). Healing traditions: culture, community and mental health promotion with Canadian Aboriginal peoples. *Australasian Psychiatry*, 11, S15-S23.

MacDonald, G. (1999). Problems, possibilities, people, power and passion: what mental health promotion is and what it is not: a response to the inaugural issue. *International Journal of Mental Health Promotion*, 1(2), 37-43.

MacDonald, G. & O'Hara, K. (1996). *Ten Elements of Mental Health, its Promotion and Demotion: Implications for Practice*. Birmingham, United Kingdom: Society of Health Education & Health Promotion Specialists.

McCormick, R. (1996). Culturally appropriate means and ends of counselling as described by the First Nations people of British Columbia. *International Journal for the Advancement of Counselling*, 18, 163-172.

McCormick, R. (2000). Aboriginal traditions in the treatment of substance abuse. *Canadian Journal of Counselling*, 34(1), 25-32.

McCormick, R. (2005). The healing path: what can counselors learn from Aboriginal people about how to heal? In R. Moodley & W. West (Eds.), *Integrating Traditional Healing into Counseling and Psychotherapy* (pp. 293-304). Thousand Oaks, California: Sage Publications.

Mussell, B., Cardiff, K., & White, J. (2004). *The Mental Health and Well-Being of Aboriginal Children and Youth: Guidance for New Approaches and Services (Vol. 1, Rep. 9)*. Vancouver, British Columbia: University of British Columbia, Children's Mental Health Policy Research Program.

Pape, B. & Galipealt, J-P. (2002, April). *Mental Health Promotion for People with Mental Illness: A Discussion Paper*. Ottawa, Ontario: Health Canada, Mental Health Promotion Unit.

Pollett, H. (2007, June 18). *Mental Health Promotion: A Literature Review*. Ottawa, Ontario: Canadian Mental Health Association. Retrieved February 29, 2009, from http://www.cmhanl.ca/pdf/Mental%20Health%20Promotion%20Lit.%20Review%20June%2018.pdf.

Royal Commission on Aboriginal Peoples. (2006, February 8). Appendix E: ethical guidelines for research. In *Report of the Royal Commission on Aboriginal Peoples*. (Vol. 5). Retrieved March 16, 2009, from http://www.ainc-inac.gc.ca/ch/rcap/sg/sgmm_e.html.

Shepard, B., O'Neill, L., & Guenette, F. (2006). Counselling with First Nations women: considerations of oppression and renewal. *International Journal for the Advancement of Counselling*, 28(3), 227-240.

Smith, L.T. (1999). *Decolonizing Methodologies: Research and Indigenous Peoples*. London, United Kingdom: Zed Books Ltd.

Smye, V. & Mussell, B. (2001, July). *Aboriginal Mental Health: What Works Best*. Vancouver, British Columbia: University of British Columbia, Mental Health Evaluation & Community Consultation Unit. Retrieved February 29, 2009, from http://www.mheccu.ubc.ca/documents/publications/discussion-paper.pdf.

The Health Communications Unit. (2007). *Evaluating Health Promotion Programs*. Toronto, Ontario: University of Toronto, The Centre for Health Promotion. Retrieved February 10, 2009, from http://www.thcu.ca/infoandresources/publications/EVALMaster.Workbook.v3.6.08.15.07.pdf.

Walker, R. (2009, May). *Social Housing and the Role of Aboriginal Organizations in Canadian Cities* (Vol. 14, No. 4). Montreal, Quebec: Institute for Research on Public Policy.

Wilson, A. (2004). *Living Well: Aboriginal Women, Cultural Identity and Wellness*. Winnipeg, Manitoba: The Prairie Women's Health Centre of Excellence. Retrieved March 24, 2009, from http://www.uwinnipeg.ca/admin/vh_external/pwhce/pdf/livingWell.pdf.

World Health Organization. (1986). *Ottawa Charter for Health Promotion*. Ottawa, Ontario: First International Conference on Health Promotion. Retrieved April 8, 2009, from http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf.

World Health Organization. (2007, September). *Mental health: strengthening mental health promotion*. Retrieved February 29, 2009, from http://www.who.int/mediacentre/factsheets/fs220/en/.

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First Peoples Child & Family Review
A Journal on Innovation and Best Practices in Aboriginal Child Welfare Administration, Research, Policy & Practice
Volume 4, Number 1, 2009, pp. 28-37

The Occasional Evil of Angels: Learning from the Experiences of Aboriginal Peoples and Social Work[1]

Cindy Blackstock

Abstract

This paper explores how the propensity of social workers to make a direct and unmitigated connection between good intentions, rationale thought and good outcomes forms a white noise barrier that substantially interferes with our ability to see negative outcomes resulting directly or indirectly from our works. The paper begins with outlining the harm experienced by Aboriginal children before moving to explore how two fundamental philosophies that pervade social service practice impact Aboriginal children: 1) an assumption of pious motivation and effect and 2) a desire to improve others. Finally, the paper explores why binding reconciliation and child welfare is a necessary first step toward developing social work services that better support Aboriginal children and families.

Introduction

Social workers have significant impacts on the lives of children and families every day- especially children experiencing maltreatment. The beliefs that we know what good is, are good, and can instill good in others, are so ingrained in the social work fabric that there is little meaningful conversation about our potential to do harm. Even when confronted by graphic evidence of harm arising from social work actions our historical response has often been to protect ourselves from seeing what we perhaps fear the most– we, the good guys, doing the harm.

The paper begins by reflecting on social work policies and practices with Aboriginal children that have been termed poor practice by many, and cultural genocide by some (Balfour, 2004), before urging the social work profession to actively engage in a meaningful process of reconciliation with Aboriginal peoples.

What's the Harm?

Herwitz (2003) argues the first step in reconciliation is to understand the harm is to hear it in a way that can not be rationalized or abided. This is a fundamental first step for social work. We must learn from our professional past in order to learn from it and avoid replicating past mistakes with Aboriginal peoples and other groups. Elder Wilma Guss (2004) suggests that those who did the harm do not have the right to define it or define the solutions to redress it – the definition of harm and the solutions to the harm are the first property of those who experienced it. The following historical summary of the harms is provided to contextualize a later discussion of possible factors eroding effective and respectful social work with Aboriginal peoples.

Aboriginal peoples have lived on the lands now known as Canada for thousands of years (Muckle, 1999). These diverse and complex societies embrace different linguistic, cultural, political and spiritual systems which reflected their distinct ecological settings. Despite their diversity, Aboriginal peoples share a common belief in the interdependence of all living, spiritual and physical forms; a preference for communal rights; and a high regard for knowledge handed down in a sacred trust from one generation to another (Auger, 2001). These beliefs influenced all ways of knowing and being, including systems for caring and educating children and youth (Auger, 2001; Sinclair, Bala, Lilles, and Blackstock, 2004). No society was ever without its challenges and each community had laws and responses to help children who were receiving inadequate care. These responses included placement of the child with other community members, conflict resolution and redistribution of community resources to ensure

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parents had what they needed to care for their children (Blackstock, 2003). Unlike today's social work practice, placement outside of the home never resulted in a complete severance of parental responsibilities to the child – parental roles were simply redefined so that the parent could safely and properly support their child to the degree they were able (Auger, 2001). To my knowledge, no Aboriginal language in Canada has a word for child removal or apprehension as we understand it in contemporary child welfare law.

Aboriginal concepts and systems of care sustained generations of Aboriginal children until the arrival of the British and French on the Eastern shores in the late 1400's and early 1500's. At the time, both colonial powers were feudal monarchies interested in expanding their respective empires with limited compromise or respect for the "savages" who lived on the new lands (Canada, 1996). Although the earliest of contact was described as mutually beneficial as Europeans traded survival information and trade access for goods, it soon changed as European motivations shifted to settlement and resource extraction. Colonial powers initiated efforts to eradicate the Indians[2] through the intentional introduction of diseases such as small pox and tuberculosis, removal of Indians from their traditional lands, imposition of restrictions of Indian movements, reckless harvesting of natural resources and, upon confederation, the regulation of Indians and lands reserved for Indians by the federal government's Indian Act (Canada, 1996).

Deaths from disease, starvation and willful murder related to colonization resulted in the complete eradication of some Indian communities such as the Beothuck of Newfoundland and an overall 80% (approx. 400,000) reduction in the Indian population from the time of contact until 1871 (Canada, 1996). This loss of life was most significantly experienced by Aboriginal children who, along with being the most vulnerable to death by disease, also experienced the profound grief and loss associated with losing so many members of their family and community.

This harm was compounded by Canada's introduction of compulsory attendance at residential schools designed to assimilate Indian children and thereby eliminate what senior government officials termed "the Indian problem[3]." These schools, run by Christian churches and funded by the federal government operated from the time of confederation until 1996 when the last one closed in Saskatchewan (Department of Indian and Northern Affairs Canada, 2003). The Indian Act authorized Indian Agents to remove every Indian child aged 5-15 years from their parent's care and place them in, often distant, residential schools. The schools themselves were poorly constructed using the cheapest possible material and workmanship and thus they were prolific incubators for the spread of tuberculosis and small pox. In fact, Duncan Campbell Scott, Superintendent of Indian Affairs for the first three decades of the 20th century estimated that up to 50% of Indian children died in the schools from disease or maltreatment (Milloy, 1999). The federal government was advised of the problem by Dr. P.H. Bryce, Indian Affairs Medical Officer as early as 1907 but their efforts to rectify it were inadequate and lacked any sustained effort. In fact, the lack of government action motivated Bryce to publish his findings in magazines and newspapers hoping that the public would become enraged and force the government into positive action. Sadly, despite Bryce's best efforts, the reports were met with silence and had little effect on government policy and practice (Milloy, 1999). This inaction prompted Queens Council S.H. Blake to note a year later that "in that the government fails to obviate the preventable causes of death it brings itself in unpleasant nearness to manslaughter" (Milloy, 1999, p.77).

There was child maltreatment as well. Throughout the history of residential schools, dating back as early as 1896, Indian Agents and others were advising the federal government of life threatening incidents of physical abuse, emotional abuse, neglect and servitude (Canada, 1996; Milloy, 1999). Even after several deaths were reported due to child maltreatment, the federal government and the churches failed to implement measures necessary to protect Indian children (Milloy, 1999). Residential schools began closing in the mid 1940's with the last federally run school finally closing its doors in 1996.

There is very little evidence that the voluntary sector, including human rights groups, did anything significant to disrupt residential schools or the colonial policies of government overall (Blackstock, 2009). Even though children's aids societies were operating in Ontario since the early 1900s (Sealander, 2003) and thus logically must have been aware of Bryce's frequent public statements about the preventable deaths of children in the schools – there is no record of children's aid ever intervening. Even as reports of abuse and neglect at the schools mounted across the country, I know of no records suggesting children's aid organizations took note of the reports or did anything meaningful to intervene. A joint submission to the Senate and House of Commons in 1946, the Canadian Association of Social Workers (CASW) and the Canadian Welfare Council (CWC) indicates that social workers were well aware of the residential schools (Special Joint Committee of the Senate and House of Commons, 1946). The CASW and CWC joint submission suggested that Aboriginal peoples should be assimilated into Canadian society and although shortcomings with the residential schools were noted, the CASW and CWC noted that "[W]e feel they [residential schools] have a place in a well rounded system of Indian education, particularly in so far as they meet special needs[4]." Even if one argued that the CASW and CWC did not, for some reason, know about the prolific and preventable deaths from tuberculosis and other factors at

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the time of their testimony, it was clearly outlined in other parts of the report where their own evidence is reproduced and yet there is no evidence that CASW or CWC took up any meaningful campaigns to address the problems.

To be fair, CASW and CWC did successfully advocate with the federal government to ensure child welfare services were provided to Indian children on reserves but this advocacy was not accompanied by a persistent campaign to close the residential schools themselves. In fact, social workers were active participants in the placement of Aboriginal children in the residential schools as late the 1960's (Caldwell, 1967; Canada, 1996).

The professional oversight bodies did not effectively monitor the quality of child welfare services mainstream social workers began providing on reserves. This lack of invigilation, accompanied by a systemic ignorance of the impacts of colonization often resulted in mass removals of Aboriginal children and their placement in non Aboriginal homes – often permanently (Caldwell, 1967). This pattern of mass removals became known as the "60's scoop." It was not unusual for so many children to be removed that a bus would be hired by child welfare workers to transport them out of the reserve (Union of BC Indian Chiefs, 2002).

Upon completing his investigation into the impacts of 60's scoop practice on Aboriginal communities in Manitoba, Judge Edwin Kimmelman said these mass removals amounted to "cultural genocide" (Balfour, 2004). Some provinces and territories responded to Kimmelman's concerns by setting temporary moratoriums on the adoptions of Aboriginal children in non Aboriginal homes but little was done to redress the poverty, social exclusion and impacts of colonization that resulted in these children being removed from their families in the first place.

In the early 1980's the federal government began to respond to First Nations demands to operate their own child welfare programs to stem the tide of children leaving the community. These programs, known as First Nations child and family service agencies, operate pursuant to provincial legislation and are funded by the federal government (MacDonald & Ladd, 2000). Although the agencies have made substantial gains in ensuring that services are culturally based and children are given the best chance to stay in their communities, they express concern regarding inequitable funding, and the imposition of provincial legislation and standards that have substantially failed Aboriginal children (Blackstock, 2003). A national policy review conducted in 2000 confirmed First Nations concerns that the current funding structure from the federal government does not provide sufficient resources for children to stay safely in their homes – although there is no funding cap on resources for children removed from their homes (MacDonald & Ladd, 2000). A more recent and detailed analysis found that the funding inequality is in the order of 109 per annum (Loxley et.al. 2005; Auditor General of Canada, 2009). This means that at home child maltreatment prevention services, which are broadly available to other Canadian children, are not provided to First Nations children on reserve resulting in an astronomical over-representation of Status Indian[6] children in care (Blackstock, 2009). Child in care data from three provinces indicates that 0.67% of non Aboriginal children were in child welfare care as of May 2005 as compared to 10.23% of Status Indian children. Overall, Status Indian children were 15 times more likely to be placed in child welfare care than non Aboriginal children (Blackstock, Prakash, Loxley & Wien, 2005).

As Maclean's magazine (2004) noted "the numbers of Status Indians taken into care has jumped by 71.5% between 1995-2001 – something experts put down to the general level of poverty and relative under funding of First Nations child welfare agencies- the situation can only fuel racial inequality and discord. In a verdict shared by adoption advocates across the country, ACC [Adoption Council of Canada] chair Sandra Scarth calls the overall situation "appalling" (Ferguson, 2004).

By 2007, the federal government had done little to redress the drastic funding shortfalls prompting the Assembly of First Nations and the First Nations Child and Family Caring Society of Canada to file a complaint with the Canadian Human Rights Commission alleging that the federal government's conscious under funding of child welfare amounted to racial discrimination within the meaning of the Canadian Human Rights Act. The federal government has not actively disputed the central claim that child welfare funding is inequitable and yet has pursued a plethora of technical objections in an apparent effort to derail or delay the hearing of this important case on its merits (Blackstock, 2009). Although this case was broadly covered in the Canadian press and the engagement of social workers is growing, there has been only modest support from non Aboriginal social work organizations.

Responding to the Harm: The Search for Social Work

One would think that responding to the needs of First Nations children and families would be a national priority for social work – the reality is that they still are not. Whilst social work authorities, academics and professional bodies acknowledge the over-representation of Aboriginal children, they typically devote very limited financial resources or sustained effort to redress it. For example, in 2004 a provincial child welfare authority allocated only 20% of its family support budget to Aboriginal families despite the fact that Aboriginal children composed over 80% of all children in care (Flette, 2005). Another province only placed 2.5% of Aboriginal children in care with culturally matched homes despite a statutory obligation to do so (British Columbia

Children's Commission, 1998). Additionally, although several non Aboriginal social work regional and national umbrella organizations will identify Aboriginal children as an organizational priority, an examination of programs, budgets and outcomes rarely reflects any significant and sustained focus that is proportionate to the scope of the problem. From a research perspective, investment in national Aboriginal child welfare research is modest representing approximately $350,000.00 in 2004 whereas the cost of keeping Status Indian children on reserve in care cost the federal government over 300 million dollars. By 2009, the reality was even more bleak with an approximate investment of approximately $100,000 nationally whilst the child welfare expenditures for First Nations children on reserves had grown to well over 400 million dollars due to rising rates of children in care. There are, of course, promising exceptions where social workers and social work organizations have meaningfully worked with First Nations to redress the over-representation of children in care but these continue to remain the exception. These positive examples need to be recognized and supported – but they should spur us on to further progressive action and not reinforce a professional slumber.

Despite the indications that social work requires a courageous invigilation of its impacts on Aboriginal families, mainstream social work largely considers itself to have taken the steps necessary to insulate itself from its egregious actions of the past. We talk about the residential school and 60's scoop eras as if they were safely packed away to ensure they do not shape current practice. But is this true? Have we as social workers really learned from our past mistakes?

The following sections explores how professional notions of improvement, professional piety, mandates and borders, knowledge and culturally appropriate services may have contributed to social work's largely poor history with Aboriginal peoples in Canada. This list is not exhaustive and is meant to inspire broad based conversation to promote professional learning.

Both Sides of Improvement

The notion of improving other people is endemic to social work. It is both a source of moral nobility and trepidation. It implies an ability to define accurately another's deficit, to locate its importance in his/her life and assumes the efficacy of external motivations and sensibilities to change. As interventions with Aboriginal children by non Aboriginal helping professionals testify it is a delicate balance between freedom and dignity of individuals and societies at one end and cultural arrogance and oppression on the other.

Research suggests that social workers should avoid drumming up solutions to "Aboriginal issues" by themselves and instead invest in a relationship where the right of Aboriginal peoples to make the best decisions affecting them is affirmed and supported. The wisdom of this approach is documented in research by Chandler and Lalonde (1998) who found that although First Nations children in British Columbia have one of the highest suicide rates in the world, more than 90% of the suicides occurred in 10% of the First Nations communities. In fact, some First Nations reported a zero percent suicide rate over the 13 years prior to the study. Chandler and Lalonde (1998) wanted to know what differences between communities that could account for such wide variation in suicide. Findings indicate that First Nations communities with a low suicide rate or no suicide rate had substantial community based decision making as represented in community based service such as child welfare, health, education, and fire and police services. Moreover, women in government and advanced stages of self government were also factors. The work of Cornell and Kalt (1992) compliments Chandler and Lalonde's findings in that they found that communities with sustained socio-economic development also had highly developed community decision making authorities. They argue that effective capacity building falls after decision making has passed to Aboriginal peoples. This finding challenges the assumption that Aboriginal peoples must build capacity to have decision making capacity passed to them.

As Chandler and Lalonde (1998) observe, in many cases Aboriginal communities already have systems in place that prevent youth suicide that are so effective youth suicide rates are substantially lower than in non Aboriginal communities. What is needed is to ensure that other Aboriginal communities have access to the information and resources needed to implement their own solutions.

This does not mean that non Aboriginal social service providers get to walk away. As many Elders have said "we did not get here alone and we are not leaving alone." It does mean shifting the philosophy of our current social work practice away from one of solution holder and service deliverer to one where Aboriginal peoples make the best decisions for themselves. Non Aboriginal peoples must play a critical and active role in making space for those decisions and ensuring adequate resources are available to implement them.

As the following section argues, it will also require a critical analysis of other factors influencing the profession such as the assumption of pious motivation and effect.

Understanding the Occasional Evil of Angels

The assumption of piety in social work blinds us from considering the need for anything along the lines of a Hypocratic Oath. The concept that we can do harm or even do evil rarely appears on the optical radar screen of professional training, legislation or practice in anything other than a tangential way through procedural mechanisms

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such as codes of ethics. This is particularly true for those of us who work with children – believing that those who want to do good, trained to do good – could do harm to children is astonishing and upsets our sensibility of the world. Talking about it even seems too much as it breathes life into its possibility so often we are silent.

On the rare occasions when there are discussions of harm in social work, and helping professions more broadly, they are predominated by inaccurate assumptions that incidents of harm will be obvious, that it is done by others, social workers will act out against it and when it does occur we will learn from it. It also wrongly assumes incidents are singular rather than systemic and that codes of ethics, professional training and standards, and anti-oppressive social work paradigms prevent its insurgence and persistence.

When evidence surfaces that harm did arise directly from the actions or inactions of social work or other helping professions we often default to rationalizing the occurrence as exceptional, using one of these predominant arguments: 1) they acted based on the sensibilities of the day – we know better now; 2) they did not know about the harm; 3) it was outside of their mandate, and; 4) if the harm is so appalling that it can not be rationalized as coming from a place of good intentions, they were immoral or bad individuals who are exceptions to the group. We have also developed systemic approaches such as the emphasis on culturally appropriate services that whilst holding great promise for supporting Aboriginal families - have also been misused as a means of limiting critical systemic analysis and professional action. This section deconstructs these rationalizations to try to understand why social workers, and others, have demonstrated very limited, if any, sustained activism against the multiple harms experienced by Aboriginal children.

Sensibilities of the Day

Some rationalize the lack of social work efforts to stop residential schools by noting that child abuse just recently surfaced on the societal radar screen as a problem deserving attention. The argument goes that "we had different standards back then – no one talked about child abuse" and thus it went unnoticed. But as John Milloy (1999) notes, the reports of child abuse at residential schools were made by people of the period who, given the sensibilities of those times, found the treatment of these children unacceptable. And yet, despite having received the reports, government officials typically did little to stop the abuse, and in some cases deaths of children.

Today we have a significant evidence base to suggest that Aboriginal children and young people face pervasive risk in a way not experienced by other Canadians and yet our professional response has been lukewarm (Blackstock, Clarke, Cullen, D'Hondt & Formsma, 2004; Blackstock, 2009). We are now the people of the period who should find such disproportionate risk unacceptable – but our professional actions are not, in my view, in keeping with the crisis before us. It is as if we have edged our collective tolerance for the risks experienced by Aboriginal children upwards to a degree where it is difficult to imagine what threshold needs to be reached for the profession to take action in a meaningful way.

We Did Not Know

Another way to rationalize the mediocre response of social work to residential schools is to argue that information on the deaths and abuses were, not until recently, widely known. As John Milloy (1999) notes this argument is weak as there was significant information on the abuse and deaths of children in residential schools and this information was available to governments, academics and the public media. The availability of this information failed to inspire progressive action to redress the abuse and murders at residential schools.

The Royal Commission on Aboriginal Peoples (Canada, 1996) found, that social workers knew about residential schools and routinely served on admissions committees adjudicating child welfare placements in residential schools (Canada, 1996). In addition to serving on placement committees, social workers actually placed substantial numbers of Aboriginal children in the residential schools. As RCAP notes, "residential schools were an available and apparently popular option within the broader child care system" (Canada, 1996, Chapter 10, p.21). According to Caldwell (1967), child welfare placements accounted for over 80% of the admissions in six residential schools in Saskatchewan. Caldwell's reports outlines a number of shortcomings in the residential school program but even he, a social worker by training, does not recommend the closure of these schools. Caldwell did, however, go further than most other social workers of his time by at recommending improvements to the residential school system.

The temptation to believe "if we had only known – we would have acted differently" may provides some false comfort but in the case of social work – it did know and acted as it acted - largely in complicit support of the residential school system.

The application of the "if we only knew we could act differently" has very little merit in today's context as well. Even with the multiple sources of information documenting the relationship between structural risks such as poverty, substance misuse and poor housing and child maltreatment (Trocmé, Knoke & Blackstock, 2004; Auditor General of Canada, 2009; Blackstock, 2009) active efforts by social workers and others to prioritize, protest and redress the

harms experienced by Aboriginal children continue to be inadequate and piece meal.

We continue to confine our assessments of child risk to the family which fetters our ability to identify risk factors that impact the child, but are sourced outside the sphere of influence of their parents and we have done little to address the longstanding inequitable child welfare funding provided to First Nations children on reserves (Blackstock, 2009; Office of the Auditor General of Canada, 2009). In missing these structural risks we set a situation in play where Aboriginal parents are held responsible for things outside their control and we deprive Aboriginal families of the same access to services as other Canadians to redress risk to children.

We Are Needed

So if information on its own is not enough to mobilize social workers, is it possible that by entrenching in the idea that social workers are positive agents for social well being, we have unintentionally build a barrier that rebuffs or rationalizes information suggesting we are perpetrating harm? Take for example the assumption that social work is in the best position to respond to child maltreatment and neglect in Aboriginal communities. Increasing evidence suggests that Aboriginal communities, when provided with adequate supports, develop the most sustainable socio-economic improvements for children and yet as a profession we continue to believe, almost at the exclusion of other options, that we are the best response. This should be a touchstone question for our profession but it is rarely asked, instead we are busy developing programs and services to offer abused and neglected children and families instead of providing communities and families with the resources to implement their own best solutions (Blackstock & Trocme, 2005).

Mandates and Borders

Another way of rationalizing the harm is to say it was outside of the mandate of the various helping professions or organizations to intervene. Take the case of Jordan, a First Nations boy from Norway House Cree Nation who was born with complex medical needs in 1999. His family placed him in child welfare care – not because he was abused or neglected but because that was the only way the provincial/federal governments would provide the money needed for Jordan's special needs (Lavallee, 2005). In a policy that baffles common sense, the federal government will not provide adequate supports for special needs children on reserve – unless they are in child welfare care. Shortly after Jordan's second birthday, doctors agreed to allow him to return home, however, as Noni MacDonald and Amir Attaran (2007) of the Canadian Medical Association Journal note, "bureaucrats ruined it." Jordan was a First Nations boy whose family lived on reserve and unfortunately, provincial and federal governments do not agree on which level of government is responsible for payment of services for children on reserve. The standard practice by both levels of government has been to defer or deny First Nations children government services that are routinely available to other Canadian children until the dispute can be resolved, with little consideration of the child's safety or well being. For Jordan, provincial and federal bureaucrats argued over every item related to his at home care while he stayed in hospital at about twice the cost (Lavallee, 2005). Days turned into weeks, weeks turned into months and Jordan saw the seasons change outside of his hospital window. All the while, bureaucrats would be meeting somewhere, likely feeling good about doing "something about Jordan's situation" while privileging their respective government's desire to not pick up the tab. It seems that they became ethically blind to Jordan's fate, and sadly Jordan died waiting at five years of age having never spent a day in a family home.

This sad example shows just how easy it is for something as insignificant as a mandate to overshadow the precious life of a young boy. This astounding story is not unique. A recent study found that in 12 sample First Nations agencies there were 393 jurisdictional disputes in the past year alone between governments around children's services (Blackstock, Prakash, Loxley & Wien, 2005). Government's put their needs ahead of children's needs far too often. Jordan's passing prompted the development of Jordan's Principle which is a child first principle to resolving government jurisdictional disputes. Although it is supported by over 1900 individuals and organizations, including growing numbers of social work organizations and governments, the reality is that as of December of 2009, no provincial/territorial or federal government in Canada has fully implemented it and I continue to receive reports of First Nations children who are being denied life saving and wellness government services available to other children because of jurisdictional wrangling.

I have often wondered what the provincial and federal officials involved were thinking when they allowed Jordan to languish in hospital. I have decided to believe that they were not evil people and yet their collective actions had devastating consequences for Jordan. I have no good answers as every rational I come up that would help me understand what the bureaucrats were thinking seems so very small in the face of Jordan's needs.

Mandates are both a necessary act of pragmatism and a cop out. They are pragmatic because no profession or institution can manage it all and a cop out because it should not support inaction in the face of gross and demonstrated immorality. Perhaps part of the reason that good people can do such immoral things in the name of mandates is

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explained by the work of Zygmunt Bauman (1989) who argues that too often our personal morality is usurped by our need to comply with what is deemed morally good by institutions we affiliate with or work with. He argues that there is a reason why whistle blowers are the exception – because they accomplish what is too rare -to break through the institutional moral code calling for company/professional loyalty to act on the basis of their moral conscience. In social work, we talk about social change but not as honestly about how our bureaucracies often prefer conformity versus courageous conversation and innovation in child welfare (Blackstock, 2009). Social change is what we do externally – but not as often internally.

The power of mandates and borders can also be more subtlety shaped by interfaces between our national, professional and personal ideology and assumptions which locate harm outside of what has already been deemed to be good. This partially explains why Canada, considered a bastion of human rights, was able to sign the Universal Declaration on Human Rights in the same year it operated residential schools, did not recognize Indians as people under the law and invited South African apartheid delegates to learn about its Indian pass system without any public protest by human rights organizations or institutions. It also partially explains why the British Columbia government was able to run a referendum on Aboriginal treaty rights in 2002 while refusing to educate the public on the treaty process. This, the first referendum on minority rights, was held with only moderate intervention by human rights groups and only a modest disapproval of the federal government. As this example illustrates, too often, non government organizations (NGO's) and human rights organizations do not think to look within Canada for human rights transgressions; instead they focused abroad. As Aziz Choudry explains "many social justice campaigns, NGO's and activists in these countries operate from a state of colonial denial and refuse to make links between human rights abuses overseas, economic injustice and the colonization of the lands and peoples where they live" (Choudry, 2001).

It is easier to believe some other society is perpetrating human rights abuses than to believe that your own country and society is – because that frames the accountability on a more personal level to do something or own the responsibility of remaining silent and still. There are few things more courageous than to stand up to people or a government that you respect and care for – especially for an interest outside of oneself. Bryce did it and should be celebrated as one of the great Canadian heroes.

Evil: A Domain of the Well Intentioned?

Another rationalization hinges on the propensity to believe that if we are well intended our actions, regardless of consequences, social workers are substantially absolved from moral responsibility. As Zygmunt Bauman (1989) notes the idea that evil is obvious and is the league of crazy individuals serves to absolve us all of being evil and affords a false security that we will know it when we see it. As a child protection worker, I have seen evil in its many faces and it has rarely been obvious or predictable. It is more often grey than black and white. It can be multi-dimensional, rationalized and normative and carried out by many instead of one. It often has benefits for someone and the benefits can seductively legitimize the costs experienced by another. As John Milloy (1999) noted, the motivations of staff at the Department of Indian Affairs and those of the churches were not always evil in the way they understood them to be – they used words like "civilizing," "integrating," "educating" to describe what they were doing. The Royal Commission on Aboriginal Peoples echoes Milloy's findings noting that "[P]olitician, civil servant and, perhaps most critically, priest and parson felt that in developing the residential school system they were responding not only to a constitutional but to a Christian "obligation to our Indian Brethren" that could be discharged only "through the medium of children" and therefore "education must be given its foremost place" (Canada, Chapter 10, p.3). This created a moral cushion that blinded them to the end result of their actions which some of their contemporaries such as P.H. Bryce and S.H. Blake found repugnant if not criminal.

This moral cushion was strengthened by limited acts that workers would carry out to redress the harm. These acts were often perfunctory and unmonitored but it served to liberate them from the moral responsibility to do something. For example, upon hearing reports of child deaths and maltreatment, staffers would often issue edicts saying it was not to happen again but nothing was done to ensure these edicts were followed up – even in the face of substantial evidence that the abuse was continuing.

These cushions have served to comfort thousands of Canadians, including those active in human rights, the voluntary sector, and academia that either contributed to the harm or stood silent in its wake. Some lived proximal to the residential schools, some read PH Bryce's article in Saturday Night Magazine, others saw the graveyards on residential school grounds or the buses collecting children from reserves to be placed in foster homes and yet, except for some courageous instances, there was silence.

Evil happens in degrees – there are those who beat children to death, those who issued edicts without following up, and those who lived next door and said nothing (Neiman, 2002). Are they all accountable? If so- how, and why? To what standard of courage and compassion should we hold social workers – are we willing to support them when they identify acts that upset our sensibilities or are

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we as a society willing to tolerate their silence in the face of atrocities. These are difficult questions that have remained underground in social work and need to be unearthed if we are to deconstruct our past reality in a way that makes obvious the thinking that fuels colonization.

Culturally Appropriate Services: A Step Forward?

In the absence of recognition of Aboriginal child welfare laws, a subsidiary movement has been underway to deliver "culturally appropriate" services. This sounds good – it feels like we are moving in the right direction as a profession but the problem is that very few of us really understand what being culturally appropriate means. This is due in part to the fact that few services are analyzed for their cultural value underpinning in order to determine what program elements are culturally predicated and on what culture. Too often services are proclaimed culturally neutral, often by those for whose cultures are embodied in the service, in the absence of any thorough analysis or search for perspective from other cultural groups. In the absence of this analysis social workers can wrongly assume that nothing needs to be changed in the fundamental elements of the service – it just needs to be made "culturally appropriate" by adding in Aboriginal symbols or ceremonies. I am open to debate on this issue but in my own experience I have yet to see a Euro-Western program of any stature deconstructed from a value perspective by Aboriginal and Non Aboriginal peoples and then reconstructed on an Aboriginal value base.

What we do know is that this movement toward culturally appropriate services has gained increasing authority as governments amended their internal operational guidelines as well as contract service guidelines to require child welfare service providers to ensure Aboriginal children receive culturally appropriate services. As a result, large numbers of organizations began redefining their services as culturally appropriate. However, as there was an absence of guidelines and monitoring bodies for culturally appropriate services, what began as an earnest attempt to better support Aboriginal children has largely degenerated to a movement that gains culturally ascribed organizations social capital and funder recognition without having to critically evaluate the cultural efficacy and relevance of their programs. I argue that the focus on culturally appropriate services takes attention away from the real need to affirm Aboriginal ways of knowing and caring for children. After all, the basic assumption underlying culturally appropriate services is that one can adapt a mainstream model for application to Aboriginal children – without compromising the basic integrity of the service – including the values and beliefs that drive it. As Aboriginal values and beliefs respecting children are very divergent from Euro-western understanding marrying the two into a coherent and effective program for Aboriginal children would be difficult. This difficulty has been well recorded by Aboriginal child welfare agencies who describe the problems inherent in delivering child welfare services to Aboriginal children within the realm of Euro-western legislation. Until there are effective evaluation and monitoring mechanisms developed to measure the efficacy of culturally appropriate services we need to be vigilant about the usage of such terms and any conclusions we may draw between said services and the well being of Aboriginal children.

Reconciliation and Social Work

After the Prime Minister's apology for the wrongs done by the Government of Canada during the residential school era, reconciliation between Aboriginal and non Aboriginal Canadians sounds like just the thing social work should be involved in– and it should. But not before it courageously engages in reconciliation itself. This means that social work must look in the professional mirror to see its history from multiple perspectives including that of those who experienced the harm. We must look beyond our need to not feel blamed so we can learn and change our behavior. It sounds trivial to write about the power of blame and shame among social workers but I have seen its power. I have seen many bright and compassionate non Aboriginal social workers raise walls of rationalization and distance to insulate themselves from it. As the doers of good, we have not been trained to stand in the shadow of our harmful actions so we ignore or minimize them. It is a privilege to put up those walls – to be able to insulate yourself from what happened. When Aboriginal people put up the wall they are left alone to deal with the harm. When social workers put up the wall they can pretend the pain does not exist at all and go about doing their daily business. The problem is that putting up the walls does not change the reality – Aboriginal peoples lost in colonization and social work did too.

Social work misplaced its moral compass and in doing so perpetrated preventable harms to Aboriginal children. It denied itself the opportunity to learn from Aboriginal cultures and make a meaningful contribution to the safety and wellbeing of Aboriginal children. As social workers we must understand that our failure to engage in an internal process of reconciliation has immobilized our strength and efficacy.

It is not enough to issue a statement on Aboriginal peoples from time to time or tinker with services if what social workers really want are justice, respect and equality for Aboriginal children and young people. We must courageously redefine the profession using reconciliation processes and then move outwards to expand the movement into society. In 2005, over 200 Aboriginal

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and non Aboriginal experts in child welfare came together to develop a process for reconciliation in child welfare and five principles to guide the process known as Reconciliation in Child Welfare: Touchstones of Hope for Indigenous children, youth and families (Blackstock, et. al., 2006). The reconciliation process is described as having four phases: truth telling, acknowledging, restoring and relating and having five principles to guide the process: self determination, holistic approach, structural interventions, culture and language and non discrimination. The touchstone principles are constitutional in nature in that they are intended to be interpreted by both Aboriginal peoples and social workers within the context of the unique culture and context of different Aboriginal groups. To be effective entire systems of child welfare need to engage in the process and embed the principles in all aspects of the work. To date, a number of First Nations and provincial/state child welfare authorities in the USA and Canada have begun implementing the Touchstone framework but social work more broadly has done little to embed the Touchstones process in its own work.

Conclusion

So although there has been some marginal progress, the lived experience of Aboriginal children and youth in Canada continues to be predominated by social exclusion, discrimination and oppression. The significant body of evidence regarding the disproportionate risk faced by Aboriginal children has been inadequate to motivate the actions needed to move them out of the categories of marginalized, at risk and vulnerable. Nor has it promoted substantial internal reflection within social work or other helping professions on what our role has been in perpetrating the harm and our concordant responsibility to understand and reconcile the harm. There is a need to affirm and support traditional ways of helping that have sustained Aboriginal communities for generations.

I look forward to a time when talking about justice for Aboriginal people is no longer an unusual or courageous conversation but is instead one that is encouraged and recognized by all Canadians as being important and necessary to affirm our national values of freedom, democracy, justice and equality. A time when the conversation of reconciliation is just as likely to be initiated by non-Aboriginal people as by Aboriginal people themselves. It is only when we, as Canadians, share what Michael Walzer (1983) describes as "collective consciousness." In creating common understanding of culture, history and language, through conversation and political action, a veracious challenge to inconsistencies in our professional social work values and concepts of justice becomes possible ensuring that democracy, freedom and equality become the real experience of every Canadian – not just a privileged few standing on one side of a one way mirror of justice (Blackstock, 2003).

To get there we must collectively make loud the legislation, values, regulations, systems and actions that perpetuate colonization and its concordant impacts on Aboriginal children and their families including those harmful and colonial philosophies and practices that are embedded in social work itself. It means understanding the harm from those who experienced it, it means setting aside the instinct to rationalize it or to turn away from it because it is too difficult to hear – or we feel blamed. It means having conversations about some of the basic values and beliefs that shape our concepts of what social work is. It means working with, versus working for, Aboriginal peoples. It means understanding that good intentions and conviction are not enough. It is about what we do in our actions that is most important. It is about embedding the reconciliation process set out in the Touchstones of Hope document throughout the social work profession.

Most of all it means not standing still – or moving just a little – it means social work takes the long journey of reconciliation. And as we walk and grow tired of the journey let the images of children like Jordan flash across our consciousness and urge us firmly forward.

Endnotes

1. This version is based on an original article published by Blackstock, C. (2005). The Occasional Evil of Angels: Learning from the Experiences of Aboriginal Peoples with Social Work. *World Indigenous Nations Higher Education Consortium Journal,* Volume 2. New Zealand.

2. The term "Indian" used in this article is used to describe Aboriginal peoples who are defined as Indian pursuant to the Indian Act.

3. Duncan Campbell Scott, Superintendent of Indian Affairs for the first three decades of the 20th Century.

4. Special Joint Committee of the Senate the House of Commons appointed to examine and consider the Indian Act. Evidence given by Canadian Association of Social Workers and Canadian Welfare Council (1946). Ottawa, Edmund Cloutier, p.158.

5. Lands set aside by the Crown for the use of Indians pursuant to the Indian Act.

6. Refers to a child who is registered or is entitled to be registered pursuant to the Indian Act.

References

Auger, D. (2001). *The Northern Ojibwe and their family law.* Doctoral dissertation submitted to Osgood Hall Law School, York University. North York: York University.

Balfour, M. (2004). *A brief history of Aboriginal Child Removal in Canada*. Retrieved 8 Jan 2004 at http://www.allmyrelations.ca/north/time/time.html.

Bauman, Z. (1989). *Modernity and the holocaust*. New York: Cornell University Press.

Blackstock, C. (2003). Restoring peace and harmony in First Nations communities. In *Child welfare: connecting research, policy and practice*, Kathleen Kufeldt and Brad McKenzie Eds. Waterloo: Wilfred University Press.

Blackstock, C., Cross, T., Brown, I., George, J. and Formsma, J. (2006). *Reconciliation in child welfare: Touchstones of hope for Indigenous children, youth and families*. Ottawa: First Nations Child and Family Caring Society of Canada

Blackstock, C. (2009). Reconciliation means not saying sorry twice: Lessons from child welfare. *From truth to reconciliation: transforming the legacy of residential schools*. Ottawa: Aboriginal Healing Foundation.

Blackstock, C., Clarke, S., Cullen, J., D'Hondt, J. and Formsma, J. (2004). *Keeping the promise: The Convention on the Rights of the Child and the lived experience of First Nations children and youth.* Ottawa: First Nations Child and Family Caring Society of Canada.

Blackstock, C., Prakash, T., Loxley, J., and Wien, F. (2005). *Wen:de We are coming to the light of day*. Ottawa: First Nations Child and Family Caring Society of Canada.

Blackstock, C. and Trocmé, N. (2005). Community based child welfare for Aboriginal children: supporting resilience through structural change in M. Unger Ed. *Pathways to resilience: A handbook of theory, methods and interventions.* Thousand Oaks, CA: SAGE.

British Columbia Children's Commission (1998). *Children's Commission annual report – 1996/1997*. Victoria, BC: The Children's Commission , 1988-v.

Canada. (1996). *Report of the royal commission on Aboriginal peoples.* Retrieved June 24, 2003 at: http://www.ainc.inac.gc.ca/ch/rcap/index_e.html.

Caldwell, G. (1967). *Indian residential schools: A research study of the child care programs of nine residential schools in Saskatchewan*. Ottawa: The Canadian Welfare Council.

Chandler, M., Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. T*ranscultural Psychiatry*, 35(2): 191-219.

Choudry, A. (2002) *Bringing it all back home: Anti-globalization activism cannot ignore colonial realities.* Unpublished Article. Retrieved December 2, 2009 from http://www.wewrite.org/Articles/Aziz.pdf.

Cornell, S., & Kalt, J. P. (1992). Reloading the dice: Improving the chances for economic development on American Indian reservations. In S. Cornell & J. P. Kalt (Eds.), *What can tribes do? Strategies and institutions in American Indian economic development* (pp. 1-59). Los Angeles, CA: American Indian Studies Center.

Department of Indian and Northern Affairs Canada. (2003). Backgrounder: The residential school system. Ottawa: Indian and Northern Affairs Canada. Retrieved October 1, 2004 from http://www.ainc-inac.gc.ca/gs/schl_e.html.

Ferguson, S. Hard Sell Adoption. (2004). *Macleans magazine*, July 26, 2004 (p.18-20). Toronto: Rogers Media Inc.

Flette, E., (2005) Personal Conversation with Elsie Flette, Chief Executive Officer of the Southern First Nations Authority of Manitoba.

Guss, W. (2004) Personal conversation with Elder Wilma Guss.

Herwitz, D. (2003) *Race and reconciliation.* Minneapolis: University of Minnesota Press.

Lavallee, T. (2005). Honouring Jordan: Putting First Nations children first and funding fights second. *Paediatric Child Health*, (10), 527-529.

Loxley, J., De Riviere, L., Prakash, T., Blackstock, C., Wien, F., & Thomas Prokop, S. (2005). *Wen: de: The journey continues*. Ottawa: First Nations Child and Family Caring Society of Canada.

MacDonald, R-A. J., and Ladd, P. (2000). *First Nations child and family services joint national policy review: Final report, June 2000*. Ottawa, ON: Assembly of First Nations

Milloy, J. (1999). *A National Crime: The Canadian government and the residential school system 1879-1986*. Winnipeg: University of Manitoba Press.

Muckle, R. (1998). *The First Nations of British Columbia*. Vancouver: UBC Press.

Neiman, S. (2002). *Evil in modern thought*. Woodstock: Princeton University Press.

Office of the Auditor General of Canada (2009). First Nations Child and Family Services Program — Indian and Northern Affairs Canada, Chapter 4. 2009 Report of the Auditor General of Canada. Retrieved May 27, 2009 from http://www.oag-bvg.gc.ca/internet/English/aud_ch_oag_200905_04_e_30700.html#hd3a.

Sealander, J. (2003). *The failed century of the child: Governing Americas young in the twentieth century*. Cambridge: Cambridge University Press.

Sinclair, M., Bala, N., Lilles, H. & Blackstock, C. (2004). Aboriginal child welfare. In *Canadian child welfare law*, second edition, Nicholas Bala, Michael Kim Zapf, R. James Williams, Robin Vogl, & Joseph P. Hornick (Eds). Toronto: Thompson Educational Publishing Inc.

Trocmé, N., Knoke, D., & Blackstock, C. (2004). Pathways to the overrepresentation of Aboriginal children in Canada's child welfare system. *Social Service Review*, 78(4), 577-601.

Union of BC Indian Chiefs (2002). *Calling Forth Our Future: Options for the Exercise of Indigenous Peoples Authority in Child Welfare*. Vancouver: Union of BC Indian Chiefs.

Walzer, M. (1983). *Spheres of justice: A defence of pluralism and equality*. New York: Basic Books.

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First Peoples Child & Family Review
A Journal on Innovation and Best Practices in Aboriginal Child Welfare Administration, Research, Policy & Practice

Volume 4, Number 1, 2009, pp. 38-46

Utilization of the Canadian Incidence Study of Reported Child Abuse and Neglect in First Nations Child Welfare Agencies in Ontario

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Abstract

The goals of this study are: to examine the awareness and utilization of the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) and the Ontario Incidence Study of Reported Child Abuse and Neglect (OIS) by First Nations child welfare decision-makers in the child welfare policy development process in the Province of Ontario and; to identify ways of making the CIS/OIS more useful to First Nations decision makers. No previous study has focused on assessing the influence and impact that the CIS/OIS data have on policy development with this specific population.

Introduction

The Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) is a national public health surveillance system that captures data on five types of child maltreatment (neglect, emotional maltreatment, exposure to domestic violence, sexual and physical abuse) (Trocmé, Fallon et al., 2005). Surveillance is a systematic process of data collection, analysis and interpretation, and communication of information on key issues. The CIS surveillance system is set up to provide national estimates about the scope of investigated and substantiated child maltreatment within the Child Welfare System. It is the only source of national child maltreatment surveillance data in Canada.

Approximately one thousand child protection workers across Canada participate in the collection of valuable information on child maltreatment allegations reported to and investigated by a representative sample of child welfare agencies. This ambitious undertaking is the result of a partnership between child protection workers located in both First Nations and main stream agencies, researchers and provincial/territorial and federal governments. This partnership is, like child maltreatment, multi-sectoral and encompasses the social, health and justice spheres.

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The CIS looks at information collected from each province and territory and incorporates it into descriptive statistics that describes the scope of the problem at the national level. However, some provinces such as Ontario have chosen to collect additional data (oversample) to obtain provincial estimates so that they can understand the magnitude and trends of child maltreatment within their own province. In Ontario, child maltreatment surveillance data have been collected since the 1993 Ontario Incidence Study of Reported Child Abuse and Neglect (OIS-1993) (Trocmé, McPhee, Kwan Tam, & Hay, 1994). With the start of the CIS in 1998, the OIS has become a component of the larger national data collection activity. Since 1998, a growing number of First Nations child welfare agencies across the country have actively participated in the CIS. In the 2003 cycle, eight First Nations agencies were involved in the data collection process (Trocmé, Knoke, Shangreaux,

Acknowledgement

This study was funded by the Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario. Dr. Jack currently holds the Reproduction and Child Health New Investigator Personnel Award from the Institute of Human Development, Child and Youth Health, Canadian Institutes of Health Research. The authors gratefully acknowledge: the participants for providing information to this study; Corinne Fox for assisting in developing the interview guide; Cindy Blackstock, First Nations Child and Family Caring Society, and the three Journal reviewers for providing helpful comments of an earlier version of this paper.

Fallon, & MacLaurin, 2005; Trocmé, MacLaurin, Fallon, Knoke, Pitman, & McCormack, 2005). Although this convenience sample is only a fraction of delegated First Nations agencies across Canada, the FNCIS-2003 can be seen as a pilot stage where a purposeful effort has been to develop capacity across cycles – both in terms of research resources and in terms of First Nations community involvement. The First Nations data are included in the CIS general report but also in specific First Nations reports. The First Nations data are obtained form delegated agencies who provide services also to First Nations populations within their jurisdictions.

Data are collected on the following areas: type of child maltreatment; nature and extent of harm stemming from the maltreatment; source of the allegation; short term investigation outcomes; child and family characteristics; child functioning; agency and child protection worker information (Trocmé, Fallon, et al., 2005).

Changes to data collection between cycles are kept to a minimum to be able to compare changes over time. At the same time the surveillance system is receptive to emerging issues that need attention. Thus, the physical abuse measures were improved between the CIS-1998 and the CIS-2003. Based on the increase in emotional maltreatment and exposure to domestic violence captured by the CIS-2003, special attention will be paid to these issues in CIS-2009. In addition, the first cycle indicated the over-representation of First Nations children in the child welfare system. CIS-1998 data indicate that Aboriginal (First Nations, Inuit and Métis) children were placed in care more often than non-Aboriginal (9.9% vs. 4.6%) (Trocmé, Knoke, & Blackstock, 2004). In subsequent cycles, efforts have been made to increase the number of First Nations child welfare agencies participating in the study to confirm and better understand the experiences of this population.

The CIS/OIS were developed to contribute evidence for planning and implementation of programs aimed at preventing child maltreatment and assisting children who have experienced child maltreatment. To accomplish these goals effectively, the data should be collected and disseminated in a timely manner. As with all surveillance systems, the CIS should detect changes in professional practice and monitor changes over time and place (Centers for Disease Control and Prevention, 2001; Stroup, 1992). To date, little is known about the utilization of CIS/OIS or the impact that this form of evidence has on child welfare policy developed to promote child health and social well-being.

Child welfare has, during the past few years, seen an increase in evidenced-based decision–making (EBD). EBD is a quest to obtain the best external evidence related to the client's issues, taking into account the specific individual in terms of the person's situation, values and preferences (Sackett, Rosenberg et al., 1996). Because of the cyclical nature of the CIS, it has a natural flow of phases: data collection, data analysis and dissemination. It provides an opportunity for reflections and improvements in each phase. In a Canadian child maltreatment surveillance context, the concept of dissemination is evolving from a passive to an interactive process (Jack & Tonmyr, 2009). This knowledge transfer and exchange (KTE) process can be defined as a collaborative and interactive process which incorporates the interchange of different types of knowledge between researchers and decision-makers (Mitton, Adair, McKenzie, Patten & Perry, 2007). Thus, KTE becomes an important concept influencing EBD.

The overall goal of this exploratory, qualitative research study is to examine the awareness and utilization of the CIS and OIS by First Nations child welfare decision-makers at the local agency level in the child welfare policy development process in the Province of Ontario. No previous study has focused on assessing the influence and impact that the CIS/OIS data have on policy development with this specific population.

The specific study objectives are to:

1. Examine the awareness of the CIS/OIS by decision-makers within First Nations child welfare agencies.
2. Explore the influence and impact of the CIS/OIS on First Nations child welfare policy.
3. Identify strategies for increasing the utility of CIS/OIS findings for First Nations decision makers.

Methods

This study is part of a larger EBD study in child welfare using both qualitative and quantitative research methods. The current study utilized information from First Nations agencies in Ontario. One First Nations member representing the Association of Native Child and Family Service Agencies of Ontario (ANCFSAO) collaborated

with the research team in developing the interview guide and an additional First Nations representative from the agency participated in the interpretation of data. This study was conducted with a specific focus on understanding how the CIS/OIS public health surveillance data are utilized by senior decision-makers in Ontario First Nations agencies. The use of a case study approach enables us to move beyond quantitative findings describing if the CIS/OIS is used in policy development to explaining how and why it is or is not utilized. Case study has been suggested as a primary qualitative design that best assists in providing detailed information necessary for the identification of competing interests in decision making such as, availability of resources and values of stakeholders where the role of research evidence may be down played (Lavis, Ross, McLeod, & Gildiner, 2003). Case study involves the study of a contemporary and contextualized phenomenon (Yin, 2003). It is a useful method to explore complex social interactions, when the investigators have limited control and when the boundaries between the phenomenon and the context in which it is situated are not well defined (Yin).

The ANCFSAO is an organization representing nine First Nations child welfare agencies in Ontario. As a mandate, members of ANCFSAO are committed to the development of and advocacy for culturally based child welfare policy and research for Aboriginal children living in Ontario (ANCFSAO, 2005). It is important to note that the limited number of FNCFSA's and the lack of staff within these organizations have to date precluded the development of policy units similar to those in mainstream agencies. Thus, much of the policy work falls to the Executive Director or front line child welfare workers in the local child welfare agency. This responsibility is added on to their other tasks. Three of the First Nations child welfare agencies in Ontario participated in this study. They were suggested by ANCFSAO. From within each organization, three key informants were identified using a process of purposeful sampling which refers to the recruitment of individuals who can provide rich, detailed and contextualized information about the phenomenon under study (Patton, 2002). In total nine key informants who were senior decision-makers within the First Nations child welfare agencies agreed to discuss their experiences and perceptions in two semi-structured in-depth interviews.

Key informant interviews are used to efficiently gather information that would otherwise be unavailable to the researcher and to obtain an understanding or interpretation of the participant's culture (Gilchrist & Williams 1999). A semi-structured in-depth interview guide derived from Dobbins, Ciliska, Cockerill, Barnsley & DiCenso's (2002) KTE work in public health was developed to address questions regarding EBD in general child welfare practice and specifically about the CIS. See Table 1 for CIS/OIS selected questions.

Data analysis was conducted concurrently with data collection for the purpose of identifying themes requiring further exploration. The initial goal of the analysis was to construct an in-depth case study that is holistic and sensitive to context (Patton, 2002). Raw case data from all sources were collected and stored as electronic documents. The qualitative software program NVivo 7.0 was used to facilitate data storage, indexing, searching, and coding. A case record, a file of all raw data organized, classified and edited, was created for each site. In the early phases of analysis, selected interview transcripts were independently coded twice by different investigators to develop a coding scheme. This coding scheme was used to code all raw data, adapting it as new concepts emerged. Coded data was then further condensed into categories or themes.

All of the interviews, except one, were audio taped and transcribed verbatim. Six of the nine interviews were conducted over the phone. The remaining three were done face-to-face at the relevant First Nations child welfare agency. The first interviews lasted between 60-90 minutes. Within six to nine months of the initial interview a second interview lasting no longer than 30-45 minutes was conducted. The purpose of these follow-up interviews was to obtain comments on the accuracy of our interpretation of the data the participant shared in the initial interview. At the start of the second interviews, the participants were given a summary of their first interview. Subsequent questions dealt with clarifying or expanding upon this information and follow-up interviews varied with each respondent. Participants were provided with the opportunity to share additional insights about the issue at this time. Ethics approval was provided by McMaster University Research Ethics Board. Because the study required neither client involvement nor information about clients, no ethics approval was obtained from the individual child welfare agencies.

Results

Nine child welfare administrators representing three First Nations child welfare agencies located in rural or remote locations participated in this qualitative study. Five of these respondents have completed the second interview to date. Reasons for not participating in the second interview varied from the participant leaving the job to the demands of a very busy schedule. This sample of child welfare administrators included three Executive Directors, and six Directors of Service with program responsibilities. College or university degrees were obtained by the majority. Six respondents had a bachelor or a master's degree in social work. Their years of experience ranged from 6-16 years (mean 13 years) in child welfare and from less than 1-8 years (mean 4 years) in the present position. These respondents were in a unique position to comment

Table 1: Selected Interview Guide - Questions Pertaining to the CIS/OIS

Knowledge of Canadian Incidence Study of Reported Child Abuse and Neglect (CIS)/ Ontario Incidence Study of Reported Child Abuse and Neglect (OIS) Reports or Major Findings (ask all questions in regards to both CIS/OIS).

a. There is a Public Health Agency of Canada document called the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS). Are you familiar with this document?

- i. Have you seen or read the full version of the document?
- ii. Have you seen or read any of the fact sheets associated with this document?
- iii. If you are not familiar yourself with this document/fact sheet yourself, is there a person or position within your agency that is responsible for keeping abreast of current, relevant research evidence?
- iv. May we contact that person? (Get contact information)

b. There is a similar document called the Ontario Incidence Study of Reported Child Abuse and Neglect (OIS). Are you familiar with this document?

- v. Have you seen or read the full version of the document?
- vi. Have you seen or read any of the fact sheets associated with this document?
- vii. If you are not familiar yourself with this document/fact sheet yourself, is there a person or position within your agency that is responsible for keeping abreast of current, relevant research evidence?
- viii. May we contact that person? (Get contact information)

If you are familiar with these documents,

c. Can you describe the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS)/Ontario Incidence Study of Reported Child Abuse and Neglect (OIS)? What do you know about these national and provincial programs of surveillance?
d. How did you become aware of the CIS/OIS?
e. When was this?
f. Do you recall where you got the reports or fact sheets from?
g. What is your understanding about some of the key messages that have been circulated from the CIS/OIS?
h. What strategies have increased your awareness of CIS/OIS findings?
i. How could research evidence/ data be more usefully presented (within your agency and generally?)

Persuasion

a. Have you been influenced by the CIS/OIS when it comes to policy or decision making? If so, how?
b. Was there a particular feature(s) of the CIS/OIS that influenced your decision to use this data?
c. What characteristics of your organization influence the utilization of research evidence (in particular the CIS/OIS) in policy development?
d. What factors support or limit your individual ability to use research evidence in policy development? (i.e lack of computers, no access to library resources etc.)
e. What is in place to promote/support integration of research knowledge into your agency?
f. Is there a process in place to provide training around understanding and using research evidence?
g. If you were able to use this research evidence (CIS/OIS) to develop policy, would you have? Why or why not?
h. What role, if any, does the Child Welfare environment in Ontario play in the utilization of research evidence in policy development? (Current social climate)

Implementation

a. Are CIS/OIS findings conveyed to staff within your agency? What about other research findings?)
b. Based on your organizational chart, which levels of staff receive this information?
c. Does every unit in your agency receive this information? If not, what determines who receives the information? (Probe front line, supervisors etc.)
d. How is this done? (Probe staff/team meetings, email, memos, training days etc.)
e. For what purpose is this information conveyed?
f. What do you think has been the impact of sharing CIS/OIS information with staff in your agency? If it has not been shared, what impact do you think that had on staff?

Confirmation

a. Describe how OIS/CIS findings have been used or integrated into practice or policy development. (Probe for instrumental, conceptual and symbolic use. Conceptual? To provide enlightenment or insight about an issue, better understanding? Symbolic? Did you use it to defend or disprove a policy, propose a new policy based on the results? Instrumental? Did the key messages result in an immediate change to a policy or practice?
b. Has the data had an impact on decisions at the agency level? If so, what type? (Probe resource allocation/reallocation; maintain, discontinue or initiate programs/services; staff training)
c. Can you provide examples of policies developed on this research evidence?
d. Have you used CIS/OIS data in other ways? (Probe for sharing it with the community, other agencies, Councils or Boards)
e. What do you think the overall impact of the CIS/OIS data has been on your organization? How could this impact level be enhanced? What has been the impact of research data generally on your organization?
f. As the child welfare system is transforming in Ontario, can you discuss how CIS/OIS data have influenced or impacted this process?

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on the use of the CIS/OIS in their agencies due to their leadership roles.

There were several questions pertaining to the CIS/OIS in the interview guide (see Table 1). General information regarding EBD in First Nations child welfare agencies will be addressed in a separate publication. The CIS related questions addressed familiarity, access, utilization in terms of practice and policy development as well as suggestions for improved dissemination.

Awareness of the CIS/OIS

Just over half of respondents were aware of the CIS, leaving almost half who had never heard about the study. There were multiple ways that the CIS had come to their attention including circulation of the CIS report within the agency, presentation of the CIS data by a CIS research team member to the agency, respondent's participation in meetings that had highlighted the CIS findings, information from the ANCFSAO and involvement in the CIS data collection process. Participants identified that they had, or were aware that they could, access the CIS findings or fact sheets through the Ontario Ministry of Children and Youth Services (MCYS), the ANCFSAO or through a general search using Google.

Knowledge of Content and Perception of Quality of the Research

Among the five respondents aware of the CIS/OIS, knowledge of specific content was scarce. Only two of the respondents reported being aware that the CIS contained data pertaining to First Nations. One of these respondents knew the prevalence of various types of maltreatment reported for First Nations children and could compare these findings to mainstream agencies. Another individual identified that the CIS data confirmed his/her understanding of the extent of child maltreatment in his/her community, although this confirmation was disturbing. For instance, in one interview, the participant perceived the dissemination phase of the study quite negatively, because of the pain associated with seeing the actual data describing the reported rates of substantiated abuse and neglect within Canadian First Nations populations of children and the outcomes experienced by these children. However, it was appreciated that a well known researcher had come to their agency. In addition the opportunity to provide feedback was valued. The respondents indicated that they had high levels of understanding in regards to the abuse/neglect experiences of First Nations children but that seeing the final numbers of substantiated abuse was shocking when it was presented back in the form of a formal report. His/her feelings are exemplified by this quote:

> *"... someone is coming and telling me all this stuff and it's hitting you real hard because it's hurtful. It's impending. It's doom. It's hurtful, hurtful things."*

Three had missed the information relating to First Nations children altogether and one was critical that the CIS did not meet their information needs, but would still consider participating in the CIS in the future in order to make the data more relevant.

> *"We did not feel that the report did the Aboriginal cause any justice. As a matter of fact, we thought it was pretty watered down and it didn't serve our purpose at all. But in spite of it, I mean we would continue to participate in the future and we might be more inclined to have some involvement with the questions in order to draw out the information more pertinent to our cause."*

Another respondent missed the inclusion of local data. The respondents who had no knowledge of the content, not surprisingly, had no opinion regarding quality.

Utilization

The questions regarding utilization addressed the CIS influence on policy development and impact on the agency. One respondent perceived that the CIS data had influenced policy changes at the level of the Ontario MCYS but that MCYS did not fully anticipate or study the consequences of their decisions and changes to policy on First Nations communities. Not all of these consequences were considered positive. As one respondent commented:

> *"...that data influenced a change of events within the child welfare secretariat...that impacted our agency and our community people, - and those two little girls that walked by right now - in a manner that affects our whole being and way of life. And [the researcher] might not think that [the] research was that important in the sense that it was used by policy makers within the secretariat to try to do the best interest for everybody but that 'everybody' doesn't always work for First Nations people and that's the sad part of it all."*

One respondent was wary of use of the CIS in policy development at the Ministerial level, since it could be construed as justification of decisions already taken. However, another respondent did not think the CIS had been used this far. At the agency level the CIS data had confirmed the management's own assessment of the extent of various types of child maltreatment in their own communities. Considering that child neglect is the biggest problem in First Nations communities and not other types of maltreatment. These children have experienced more neglect due to poverty, poor housing and substance misuse, issues that have to be addressed at multiple levels including the individual, family and community and structural changes. The CIS validated the respondents own impressions that:

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> *"child welfare is more complex than just snatch and grab…it isn't about enforcement; it's about good social work."*

One respondent would not use the CIS data at the agency level because the respondent felt that policy development at the agency level "is more intuitive, it is more experiential."

Suggestions for Dissemination

In terms of suggestions for the dissemination of findings emerging from the CIS, all of the respondents had ideas on how to improve effective communication of scientific data to their communities. It was reinforced that oral communication is the preferred approach rather than distribution of written reports. It was appreciated that members of the CIS research team had come back to the participating community to present the results of the study. The presentations of research findings should preferably be given in person but respondents were not unfamiliar with or opposed to using technology, such as the internet, video and audio tapes. The reporting back should be "interactive and fun," using visuals like PowerPoint. It was also suggested that presentation could be given at regional debriefings. One respondent stated:

> *"value for me comes from…our own people…I do believe there is value*

[for First Nations] in research in mainstream system as well."

Another respondent acknowledged that two out of three researcher/research assistants that had been involved with CIS data collection came from First Nations communities.

Another idea that was expressed was the need for linking the CIS results to practical interventions. Child protection workers need to "understand how [the data] can be useful, about the practical implications." Research will only be useful if it is relevant and one of the key functions of child protection work is knowing how to intervene with clients.

> *"If we're given information on initiating a new process or anything in that regard like a way that [is] showing us - you know - this may work better this way, research has shown that this may be more helpful, we'll definitely try it, if it'll work in our area."*

Discussion

The CIS is a major surveillance project that according to this study has only been marginally successful in reaching and being useful for First Nations agencies in Ontario. The findings from this study are limited by the small sample size of nine senior decision-makers within First Nations child welfare organizations from rural or remote locations. The geographic location of these agencies may have impeded decision-makers' abilities to develop networks with researchers and/or attend meetings or conferences where the CIS data had been promoted. Problems in accessing evidence were identified as a barrier to research utilization in mainstream agencies also (Jack, Dobbins, Tonmyr, Dudding, & Brooks, 2009). It is important to note when the respondents had participated in the CIS, they were more knowledgeable both about CIS and research in general. This is not surprising since reports were sent by mail and email to participating agencies and face-to-face presentations were offered. Overall however, it is important to recognize that despite the small number of First Nations agencies in Ontario, First Nations participation in the CIS has improved since its inception at a national level. In CIS-1998, three First Nations agencies participated, in CIS-2003 eight agencies took part in the study and in CIS-2009 it is planned that twenty First Nations agencies will be data collection sites. This increase will provide better and more detailed information on First Nations children and communities. CIS-2009 data may thus have more relevance to First Nations child welfare agencies, hopefully increasing its usage. It has also been recognized after CIS-2003 that all components of surveillance (data collection, data analysis and dissemination) take considerable resources (Jack & Tonmyr, 2009). Dissemination of findings to First Nations organizations, particularly those in rural or remote locations that value face-to-face oral communication requires resources dedicated for researchers to travel long distances to the home organizations.

As the field of knowledge translation and exchange evolves, there will be in some contexts greater expectations on researchers, who are often perceived as credible messengers (Lavis et al, 2003) to assume greater responsibilities for disseminating information using strategies and communication channels beyond traditional means of publications and conferences (Denis, Lehoux & Champagne, 2004). This requirement to actively participate in KTE activities places a great responsibility and burden on many scientists primarily engaged in the production of evidence. Additionally, some researchers may lack the knowledge, skill or inclination to effectively disseminate evidence effectively to different target audiences. In relation to the dissemination of the CIS, a national surveillance program, with multiple different target audiences, there is then a responsibility for multiple individuals and organizations external to the primary research teams to assume the intensive activity of disseminating findings.

One way of improving the use of research evidence in the decision-making process is for decision makers and researchers to work together in both the production of knowledge and dissemination phase (Innaer, Vist, Trommald & Oxmann, 2002; Tonmyr, De Marco, Hovdestad & Hubka, 2004). This may be even more important in First Nations communities. However, this is challenging

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considering the varied response to the CIS. One of the respondents focused on the numbers and statistics reported in the CIS meanwhile others were emotional in their data interpretation, i.e., crying when thinking of First Nations children who have experienced maltreatment. Anticipating these diverse responses may assist in dissemination. For instance, it has been suggested from clinical social work literature that it is important to understand and assess if a decision is based on “head” or “heart” activity in order to meet the needs of children. Since, humans are not automatons, utilization of evidence is influenced by a range of factors (Howarth, 2007).

Taking these points to heart, changes have been made between cycles of data collection regarding First Nations content. In CIS-2003, questions were added regarding the child’s Aboriginal status (First Nations status; First Nations non-status; Métis; and Inuit). The CIS-2009 questionnaire will be changed to include the following questions: caregiver attended residential school; grandparent attended residential school; band housing; and referral to alternative dispute resolution program (e.g., Aboriginal circle). These changes took place after consultations with First Nations representatives and were seen as important elements in creating a knowledge base for First Nations child welfare agencies. In addition, a First Nations steering committee was formed in September, 2007 with representation from across the country. It is also important to note that First Nations representatives have since the inception of the CIS been represented on the CIS steering committee and been involved in all phases of the CIS. There has been many First Nations and non First Nations champions for inclusion and better First Nations CIS data in the various cycles. This committee has communicated on a regular basis to guide the CIS in important questions such as First Nations Ownership, Control, Access and Possession over the data (First Nations Centre, 2007).

One identified limitation of the CIS was the need for practical intervention data. Clearly the overall purpose or function of surveillance data in general, and the CIS in particular, have not been well communicated. The primary purpose of the CIS and other surveillance system is to describe the problem, estimate the magnitude of the problem and analyze trends. Another identified limitation was the need for local data, which was also echoed in main stream agencies in Ontario (Jack et al., 2009). This limitation of the data has been recognized (Trocmé, Fallon et al., 2005) and initial discussions have started on how to improve local data. In the meantime the national level data can still useful at the local level. Although the gap between national problems and local situations is wide, clearly more effort is needed to:

- Convey how the two levels are linked;
- Compare national level data to local agency statistics to question the local practice and allocate resources appropriately; and
- Show how surveillance information and relevant research findings can be woven together to help develop useful strategies for local First Nations communities.

Albeit not well articulated, respondents seemed to have expectations that the CIS would illuminate strategies for prevention and intervention. However, other types of research are best suited to explore and provide this type of knowledge that can complement surveillance findings. The role of surveillance data is just to provide pointers and indications of where targeted research efforts are needed.

It is encouraging that CIS data may influence the policy debate at the provincial level. It was perceived that the CIS data had influenced policy changes in Ontario, while well intended, some of these changes have had unanticipated impact on First Nations communities. Increased communication and consultation between policy makers at the Ministry level and First Nations decision makers would be beneficial to all parties. CIS data can serve as a source of background information to policy development. For instance, CIS data found no differences in placement of Aboriginal children compared to non Aboriginal children when aforementioned hard ships such as poverty and drug abuse were considered (Trocmé, Knoke, & Blackstock, 2004).

It is also important to note that although CIS data have only started to impact policy making in Ontario and the rest of the country. The national level First Nations CIS data have been the foundation on which to challenge discrepancies in funding between First Nations and mainstream child welfare agencies. This has been acknowledged by the Auditor General (Office of the Auditor General of Canada, 2009). The CIS data has also been used in the complaint field at the Canadian Human Rights Commission by the Assembly of First Nations and the First Nations Child and Family Caring Society alleging that Canada violates child welfare legislation and the Charter of Rights and Freedoms and that First Nations children are receiving unequal benefit (Blackstock, 2009).

This research project was undertaken in part to help direct improvements to the CIS/OIS. The results clearly show that the CIS needs to be better disseminated in First Nations communities and the innovative methods that were suggested by the respondents need to be implemented when possible. The idea of using technology, such as video conferencing, to allow remote presentation of research data, and the openness of First Nations communities to consider this method of information sharing needs to be considered as this would allow access to other experts without the cost of face-to-face meetings. The visits from a representative of the research team in participating agencies were seen as positive and were well received. However, these efforts

need to be complemented by other strategies. For instance, it is important to engage a respected and knowledgeable community member (e.g., elder) to build on localized and culturally appropriate knowledge. These community members may be able to illuminate links between the local situation and the CIS findings. In addition, through technical assistance, such as video conferencing, a dialogue may be initiated with respected experts outside the immediate community. These experts could, for instance, include members of the First Nations CIS Steering Committee.

Although this study is an important first step in understanding the utilization of the CIS by senior decision makers in First Nations agencies the data suffers from two limitations. The first is the small number of First Nations child welfare agencies in Ontario and the second is the lack of generalizability of findings outside of remote locations in Ontario.

Further research is warranted regarding EBD making in First Nations agencies. The qualitative interviews will assist in providing detailed descriptive information about how EBD making is used and barriers to its use in First Nations communities. Meanwhile, the quantitative data stemming from the second phase of this EBD study will provide additional knowledge through providing an overview of barriers and facilitators to the use of EBD making in Ontario. Considering the different organizational structures and the limited number of First Nations child welfare agencies in Ontario, a survey of First Nations agencies across the country would be desirable for a better understanding of the utility of the CIS.

Conclusion

This research project has been the first study in Canada that has systematically analyzed the utilization of the CIS/OIS in First Nations communities. It identified some fundamental challenges for KTE. Although many respondents were unaware of the CIS/OIS, those who had participated in the CIS knew the data better. All respondents assisted in providing insight into the identification of strategies for making the data more useful to First Nations child welfare agencies, through for instance linking the CIS data to practical interventions. It also provided input for more effective dissemination of the findings through the use of face-to face meetings and technological interactive means.

References

Association of Native Child and Family Service Agencies of Ontario (2002). Retrieved December 16, 2005 from http://www.nativecfs.org.

Blackstock, C. (2009). Reconciliation means not saying sorry twice: Lessons from child welfare in Canada. In: The Aboriginal Healing Foundation, Castellano, MB., Archibald, L. and DeGagné M. *From Truth to Reconciliation, Transforming the Legacy of Residential Schools*. Ottawa: Aboriginal Healing Foundation.

Centers for Disease Control and Prevention, Guidelines Working Group (2001). Updated guidelines for evaluating public health surveillance systems. *MMWR*, 50(RR13), 1-35.

Denis, J., Lehoux, P., & Champagne, F. (2004). A knowledge utilization perspective on fine-tuning dissemination and contextualizing knowledge. In L. Lemieux-Charles & F. Champagne (Eds.), *Using knowledge and evidence in health care: Multidisciplinary perspectives* (pp. 18-40). Toronto, ON: University of Toronto Press.

Dobbins, M., Ciliska, D., Cockerill, R., Barnsley, J., & DiCenso, A. (2002). A framework for the dissemination and utilization of research for health-care policy and practice. *The Online Journal of Knowledge Synthesis for Nursing*, 9, Document 7.

First Nations Centre. (2007). *OCAP: Ownership, Control, Access and Possession. Sanctioned by the First Nations Information Governance Committee, Assembly of First Nations*. Ottawa: National Aboriginal Health Organization.Retrieved July 16, 2009 from http://www.naho.ca/firstnations/english/documents/FNC-OCAP_001.pdf.

Gilchrist, V.J., & Williams, R.L. (1999). Key informant interviews. In B. Crabtree & W. Miller (Eds.), *Doing qualitative research* (2nd ed) (pp. 71-88). Thousand Oaks: Sage.

Horwath, J. (2007). The Missin Assessment Domain: Personal, Professional and Organisational Factors Influencing Professional Judgment when Identifying and Referring Child Neglect. *British Journal of Social Work*, 27:1285-1303.

Innvær, S., Vist, G., Trommald, M., & Oxman, A. (2002). Health policy-makers' perceptions of their use of evidence: A systematic review. *Journal of Health Services Research & Policy*, 7, 239-244.

Jack, S., Dobbins, M., Tonmyr, L., Dudding, P., & Brooks, S. (2009). *Factors influencing evidence based policy and research utilization by child welfare administrators*. Submitted.

Jack, S., & Tonmyr, L. (2009). Knowledge transfer and exchange: Disseminating Canadian child maltreatment surveillance findings to decision makers. *Child Indicators Research*, 1(1), 51-64.

Lavis, J.N., Robertson, D., Woodside, J.M., McLeod, C.B., Abelson, J., and the Knowledge Transfer Study Group (2003). How can research organizations more effectively transfer research knowledge to decision makers? *The Millbank Quarterly*, 81, 221-248.

Lavis, J., Ross, S., McLeod, C., & Gildiner, A. (2003). Measuring the impact of health research. *Journal of Health Services Research and Policy*, 8, 165-170.

Mitton, C., Adair, C.E., McKenzie, E., Patten, S.B., & Perry, B.W. (2007). Knowledge transfer and exchange: Review and synthesis of the literature. *The Milbank Quarterly*, 85, 729-768.

Office of the Auditor General of Canada (2009). *Report of the Auditor General of Canada to the Legislative Assembly*

of Nunavut, Nunavut Housing Corporation. Ottawa. Retrieved 8 July 2009 from http://www.oag-bvg.gc.ca/internet/docs/200905nhc_e.pdf.

Patton, M.Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing and Health*, 18, 179-183.

Stroup, D.F. (1992). Surveillance data for policy: A national and state approach. *MMWR*,41(Suppl), 135-141.

Tonmyr, L., De Marco, R., Hovdestad, W.E., & Hubka, D. (2004). Policy makers' perspectives on the utility of a national study of child maltreatment. *Child Maltreatment*, 9, 304-308.

Trocmé, N., Fallon, B., MacLaurin, B., Daciuk, J., Felstiner, C., Black, T., Tonmyr, L., Blackstock, C., Barter, K., Turcotte, D., & Cloutier, R. (2005). *Canadian incidence study of reported child abuse and neglect-2003: Major findings*. Ottawa, ON: Minister of Public Works and Government Services Canada.

Trocmé, N., Knoke, D., & Blackstock, C. (2004). Pathways to overrepresentation of aboriginal children in Canada's child welfare system. *Social Services Review*, 8(4);577-601.

Trocmé, N., Knoke, D., Shangreaux, B., Fallon, B., & MacLaurin, B. (2005). The experience of First Nations children coming into contact with the child welfare system in Canada: The Canadian Incidence Study of Reported Child Abuse and Neglect. In First Nations Child & Family Caring Society of Canada, *Wen: De: We are Coming to the Light of Day*. Ottawa, ON: First Nations Child and Family Caring Society of Canada: p. 60-86.

Trocmé, N., MacLaurin, B., Fallon, B., Knoke, D., Pitman, L., & McCormack, M. (2005). *Understanding the overrepresentation of First Nations children in Canada's child welfare system: An analysis of the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2003)*. Toronto: Centre of Excellence for Child Welfare.

Trocmé, N., McPhee, D., Kwan Tam, K. & Hay, T. (1994): *Ontario incidence study of reported child abuse and neglect. Final report*. Toronto, Ontario: The Institute for the Prevention of Child Abuse.

Yin, R.K. (2003). *Case study research: Design and methods* (3rd ed.). Thousand Oaks, CA: Sage.

First Peoples Child & Family Review
A Journal on Innovation and Best Practices in Aboriginal Child Welfare Administration, Research, Policy & Practice
Volume 4, Number 1, 2009, pp. 47-56

Fetal Alcohol Spectrum Disorder Standards: Supporting Children in the Care of Children's Services

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Abstract

The purpose of this research was to examine the utilization of enhanced practice standards for children in care with Fetal Alcohol Spectrum Disorder (FASD). Children in care with FASD represent a vulnerable population and require multiple supports from a cross-disciplinary perspective. Children removed from the care of their parents were identified as having needs beyond standard care provided within Children's Services in Alberta. To address this concern a project was initiated in 2002 and completed in 2005 which identified positive benefit from an increase in caseload hours for workers responsible for children with FASD in the Aboriginal Unit including more contact with children and additional supports for foster parents. Standards regarding family visitation are also highlighted. An additional casework position was developed in order to decrease caseloads and meet the standards. Changing the way child welfare and foster care services are delivered for children with FASD is an important phenomenon to study and this research may guide future interventions.

Introduction

Fetal Alcohol Spectrum Disorder (FASD) is a complex phenomenon in our society. Although identified as preventable, the issue of alcohol use during pregnancy and the consequence of children diagnosed with FASD require extensive interventions with women with traumatic histories to support prevention. Often, children who are raised in homes where alcohol is a problem end up in the care of the state. The focus of this research was to evaluate FASD Practice Standards for children in the care of Alberta Children's Services. This research offered the opportunity to examine the issues and efforts in child welfare practice to address concerns for children, families and caregivers living with FASD.

Hutson (2006) estimates that "3000 babies are born with FASD in Canada" and cites a report from the Child Welfare League of Canada (2003) which further estimates "that 50% of children in care in Alberta have FAS" (p. 2). Alberta Health Services suggests that it is estimated that 9 of every 1000 births has a fetal alcohol spectrum disorder. Fuchs, Burnside, Marchenski and Mudry (2005) in their research of children in the care of child welfare agencies in Manitoba estimated that 17% of children in care have a fetal alcohol spectrum disorder. Variance amongst prevalence rates exist as there is not a coordinated approach in Canada to gathering this information.

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Origins of the Development of FASD Practice Standards

In 2001, a group of community stakeholders and child welfare professionals met in Lethbridge, Alberta and collaboratively agreed that children in care with Fetal Alcohol Syndrome (FAS) / Fetal Alcohol Spectrum Disorder (FASD) were not being adequately served by existing standards of care. The major reason behind the decision to examine this problem was the concern about the complex needs of children with FASD primarily due to disabilities resulting from alcohol exposure in-utero. This led to the design of practice standards specific to the identified needs of children in 2002. The standards directly related to child welfare intervention included: screening for FASD, child assessment, parenting ability, case plans, case plan review, home visits, case worker contact, child and

family awareness of FASD and permanency planning. Key standards related to management of the project addressed training for staff and caregivers, assessments for youth and parents, support for foster parents, kinship care, transition to adulthood, case worker contact and case plan reviews.

Once the standards were developed, Region 1 of Alberta Children's Services contacted the Faculty of Social Work, University of Calgary to request assistance in evaluation of this project. Funding for this research came from the Alberta Centre for Child, Family and Community Research (ACCFCR) in 2003. The standards were field tested in 2002 and fine tuned and this pilot research project ran from 2003-2005. An extensive final report was completed in 2005 (Badry, Pelech and Norman). The full report is located online on the FASD Connections Website (http://www.fasdconnections.ca/id112.htm).

The initial challenge of this research was that no prior published research literature existed regarding the care of children with FASD who were in the care of the state. Social science research has not kept pace with biomedical research in relation to FASD and this posed a challenge in terms of research direction and design. Streissguth (1997) and Streissguth and Kanter (1997) published seminal research in terms of not only the medical conditions associated with FASD, but the profound social/behavioral/familial problems associated with a diagnosis. A host of neurobehavioral, psychosocial and health issues seemed inherent with a diagnosis of FASD.

In presenting this research it is critical to highlight important issues relevant to child protection. This paper represents the FASD Practice Standards research as well as some philosophical considerations in the delivery of services to children with FASD. Having worked for 16 years in child welfare (1986-2002) I had the opportunity to witness the growing awareness of FASD as a concern in child welfare practice. My interest in research related to FASD emerged from the opportunity to work with a 16 year old youth in 1986 whose mother was alcoholic. He had visible characteristics of FAS but diagnostic clinics did not exist at the time. He told me he had problems because his mother drank while pregnant with him. I never met his mother as he was an emancipated youth. Today, this young man would likely have access to a diagnostic clinic and subsequent supports for children with FASD that were not available 20 years ago. This signals progress in our understanding of FASD but there is still a long way to go in developing practice models. The FASD Practice Standards research signals a beginning.

Brief History of Fetal Alcohol Syndrome / Fetal Alcohol Spectrum Disorder

The medical system opened the social discourse on FAS by raising the issue in France (Lemoince, 1968) and by Jones, Smith, Ulleland and Streissguth (1973) in North America. These researchers recognized that a cluster of children existed with similar physical features and medical problems, and recognized the common linkage between these characteristics was the teratogenic or toxic effects of alcohol on the developing fetus. They named this condition, Fetal Alcohol Syndrome (FAS). The term FAS describes a myriad of features, both physical and neurological. It does not address the social dimensions and consequences related to the phenomenon of living with the condition. The medical system has become the primary informant about this topic as a public health issue. The scientific study of the teratogenic effects of alcohol on the developing fetus has evolved into a complex field of medical assessment and diagnosis, and FAS has been identified as a topic of great concern to society.

Recent literature offers the term Fetal Alcohol Spectrum Disorders, as a term that refers to the many conditions that can result from prenatal alcohol exposure (Streissguth and O'Malley, 2001). The term FAS was frequently referred to in the literature that predates 2002-2003. The term FAS has more recently become housed by the medical profession under a broader description, known as Fetal Alcohol Spectrum Disorder (FASD) (Streissguth and O'Malley, 2000). The medical profession has indicated that multiple conditions exist along the spectrum of potential disorders resulting from alcohol exposure in utero and utilizing an umbrella term promotes common understanding that the cause of the problems a child lives with are alcohol related (O' Malley and Streissguth, 2002).

Canadian researchers have developed Canadian Guidelines for Diagnosis (Chudley et al., 2005). While the physical etiology of FAS / FASD was well documented, the social etiology slowly unfolded as awareness grew of the profound impact of alcohol exposure on human development. In particular, Streissguth (1997) was a pivotal researcher in bringing awareness to the psychosocial issues related to a diagnosis of FAS (Streissguth, 1997, Streissguth and Kanter, 1997) and FASD (Streissguth and O'Malley, 2001).

A Moralized Discourse Underlies Complex Social Issues

If the term 'prenatal substance abuse' is used, a woman is immediately implicated as guilty and placed within a dichotomous framework where harm / control of her body is weighed against harm / control to the fetus. A less loaded term to utilize instead is alcohol exposure in utero, to diminish stigma. Framing the issue of FASD from a child protection standpoint immediately places a mother in conflict with this system. The welfare of children is considered to be a public issue. One of the roles of women as mothers is to protect children from harm. Through a societal lens and driven by a dominant medical response to

this issue, women who drink during pregnancy are causing undue harm to their children. One of the problems with this position is that not all women who drink during pregnancy give birth to children with FAS. However, women who do give birth to children with FAS are perceived as unfit, portrayed as irresponsible and even malevolent.

In reflecting upon the birth of children with FASD, it is important to contextualize the experience of women. Fetal Alcohol Spectrum Disorder, in contemporary Western society, has become overtly represented as a moralized disability. As such, the evolution of a prevailing discourse, grounded in the bio-medical definition of FASD, that suggests if only women refrain, by choice, from alcohol use during pregnancy, then FASD will cease to exist. Discourse on prevention suggests if pregnant women do not refrain from alcohol, then these mothers-to-be must be held responsible – ethically, socially, morally, medically, politically – for any alcohol-related difficulties the child experiences. I raise this issue as my doctoral dissertation was about birth mothers of children with FAS and I sought to humanize their experience through my research. The intergenerational issues of FAS/FASD will only be mediated by protecting all children from physical, sexual, emotional abuse and neglect. The problematic use of alcohol within our society is rarely mentioned in discussions about FASD.

According to Poole (2007) a focus on Aboriginal women based on limited research has resulted in negative assumptions of higher prevalence than other populations. More recently, studies have come forward which provide a critical analysis of the topic of the social construction of knowledge about women who consume alcohol during pregnancy and the language used to describe this topic (Ferguson, 1997; 2003a; Armstrong, 2003; Boyd, 2004; Boyd and Marcellus (2007). For example, Tait, (2000 a2003b) engages in a sociological analysis on The Tip of the Iceberg: The Making of Fetal Alcohol Syndrome in Canada in her doctoral dissertation, suggesting FAS has been constructed as a response to stigmatize the First Nations people of Canada and North America. Berube (2005) represented birth mothers with the metaphor of "modern lepers" due to her perception of the negative societal response to pregnant, alcoholic women. Armstrong and Abel (2000) have flagged a concern about identifying "moral disorder" in women through the diagnosis of their children with FAS (p. 276).

Tait (2003b) stated the following:

> *Despite the negative impacts of the residential school system and other forms of colonization, it should be pointed out that not every former student responded in the same way to their experience and, for various reasons, some individuals and communities did better than others did. Because of this alcohol abuse among Aboriginal people in Canada varies and it should be understood as a problem of certain individuals and subpopulations, rather than a problem of all Aboriginal people. In relation to [FAS / FASD], this suggested that programming and services should target those particular populations who are at risk, rather than targeting all groups regardless of the alcohol use levels (p. xv).*

Poole (2009) identifies a child-centred focus as a barrier to "understanding women's substance use in pregnancy and into developing the interventions needed to prevent this use and/or mitigate the harms associated with it" (p. 290). The implications of a diagnosis of FASD are far reaching for both a child and mother. Social science research related to fathers has lagged with only one published study regarding the role of fathers (Gearing, McNeill and Lozier, 2005).

Barr & Streissguth (2001) raise the issue of maternal self-report in relation to supporting a diagnosis since no standardized test exists to assess the level of alcohol exposure to a fetus. It is not unusual for women to under report their substance use out of fear of consequences such as a referral to child welfare and risk of child apprehension. Streissguth (1997, 2002) reported on research occurring as early as 1974-1975 in the Seattle area, on women using drugs and alcohol who were involved with prenatal care. Streissguth suggested that knowledge of alcohol exposure is important in not only identifying those at risk, but can also be a support in early planning and intervention that can mediate against child protection concerns for the family.

Precursors that lead to alcohol use during pregnancy include a history of childhood sexual abuse, and alcoholism within the family of origin (Tait, 2003). Marsh and Dingcai (2005) report that substance abuse is a major factor in the removal of children from parental care and recommend an intervention model which integrates child welfare and substance abuse treatment, in the interest of better outcomes for children. Grella, Hser and Huang (2006) suggest that early intervention with parental substance abuse treatment may "interrupt their substance use prior to progressing to later stages of addiction severity" (p. 69). Multiple measures are critical for a diagnosis of FASD and maternal self-report alone cannot support a diagnosis. There is often discomfort on the part of health or social service professionals around asking about alcohol use in pregnancy. Although information on the consumption of alcohol use during pregnancy is a critical part of a diagnostic assessment for FASD, this is an extremely sensitive issue that must be cautiously addressed. Asking the question of alcohol use during pregnancy in a child protection investigation can traumatize women and further research on this topic is required.

Grant, Ernst, Streissguth and Porter (1997) suggested that many women are reluctant to reveal their use of alcohol

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during pregnancy because of fear of judgment, alienation, and removal of the child from their care. The issue of fathers is rarely mentioned in the literature with only one study emerging which highlights the concern that the influence of fathers has largely been ignored, yet their role is relevant and further research in the area of FASD and the family is required (Gearing, McNeill and Lozier, 2005). Tait (2000a) suggests that relationship problems within families, community and with male partners contribute to alcohol misuse. A holistic view of the problems associated with the diagnosis of a child with FASD may be difficult to establish because families are often fractured through child apprehension and placement in foster care. If the misuse of alcohol and substance abuse are not mediated through treatment and support, the risks to children in the home remain problematic. Streissguth (1997) indicated that birth mothers lives are often "out of control on all fronts" (p. 271), and child protection is often required. As well, intensive in-home supports are required for the birth mother if the apprehended child was to return to parental care.

The concerns of child protection for children of alcoholic mothers are very serious and cannot be minimized. Alcoholism is a serious issue within families but it needs to be contextualized within the historical experience of families. Blaming women as the cause will not support decreasing births of children with FASD. Women who find themselves in this circumstance of becoming birth mothers have complex histories. Perry (2002) identified The Vortex of Violence as the ways in which children adapt to living in violent circumstances. There is an intergenerational cycle in which girls that are abused as children find ways to adapt as they grow up. Perry stated, "Persisting fear and adaptations to the threat present in the vortex of violence… contribute to the transgenerational cycle of violence as these young children become adolescents – and finally, the adults that shape our society" (p. 4). Alcohol use is often a co-morbid factor in violence.

The way parents are treated in child protection matters influences the outcomes for children in care. The way caseworkers interact with parents is critical and standards that guide that practice are imperative in the interests of better outcomes for children and families. One of the realities is that parents themselves may be alcohol exposed and this presents challenges in practice. The complexity of FASD, the need for psychosocial and medical intervention from an interdisciplinary perspective alone suggests that a model of specialized practice is required. As knowledge has grown about FASD the possibility exists to develop new models of practice and interventions that may challenge current policy practice frameworks.

Child Protection Framework

It is important to contextualize the framework which has driven the need to respond to FASD differently by establishing specific casework standards. The issue of child neglect is a concern in families where substance use is a problem. The active alcoholic can experience difficulties in meeting the needs of their children and security in the home environment becomes disrupted. Poverty is also a concern and those children experiencing neglect are more likely to come from homes without full time employment outcome and utilizing other sources such as social assistance, other pensions or part time work (Roy, Black, Trocmé, MacLaurin and Fallon, 2005). Lack of stability creates risk for children with FASD as routine and structure mediate their neurodevelopmental disabilities.

Vig, Chinitz and Shulman (2005) completed a study that examined young children in care with complex needs and multiple vulnerabilities, and suggested that 80% may have had prenatal exposure to alcohol. Factors cited in removal of children from parental (biological) care broadly includes "neglect" and "parental incapacity" (p. 147). Aronson, (in Streissguth & Kanter,1997) suggests that "even though early fostering did not appear to eliminate the harmful effects of exposure to alcohol in utero, foster care seems to be the most favorable alternative for children whose biological mothers, despite vigorous attempts at psychological support, continue to abuse alcohol and have severe personal psychological problems. Children prenatally exposed to alcohol who remain in biological families…remain at continued risk" (p. 24). For children with FASD, stability and structure are hallmarks of good care.

A phenomenon of concern that has been addressed in the literature by Streissguth (1997); Grant, Ernst, Streissguth and Stark (2005) is the lives of birth mothers. There are not many opportunities to raise the voices of birth mothers which suggest they are a disenfranchised population. It is important that the concerns of birth mothers be raised in the discourse because it will help deepen an understanding of families where child welfare engages in protection/apprehension interventions. Some of the characteristics from my own qualitative research on eight birth mothers, primarily non-Aboriginal was that they were often single mothers, had unplanned pregnancies, engaged in transient relationships with others, had a history themselves of child welfare involvement, often combined alcohol and drug use and were exposed to alcoholism in their families of origin. This leads to women with fragile histories becoming invisible to the system once their children are apprehended due to their difficulties in trusting others and viewing systems such as child welfare as a threat rather than a support (Badry, 2009).

The reason it is important to highlight the concerns of

the mother is that interventions in child welfare focus on the child and not on the needs of the mother. Perhaps a deeper understanding of the history of birth mothers who themselves often have histories of abuse and neglect can lead to a more compassionate response for birth mothers and guide interventions related to family functioning. An important concern is the possibility that the birth mother may have been alcohol exposed which has implications for finding ways to work effectively with families and designing accommodations in service delivery for both mother and child, perhaps decreasing the need for apprehensions. This concern also leads to the question of adult diagnosis which is currently a topic of interest in Alberta (Clarren and Lutke, 2009). Knowledge about birth mothers may help child welfare to better understand women's issues related to parenting. Additionally, intergenerational issues will not be resolved if the healing process excludes rather than includes the family. This topic warrants further exploration but is beyond the scope of the current research.

Another concern for children is the importance of living in an environment where they have the opportunity to develop secure attachments with immediate and extended family wherever possible. With active substance misuse, secure attachment is a concern for infants and young children. Disrupted attachment is a consequence of substance misuse due to its disruption of the nurturing parent/child relationship. Concern for children with FASD around their ability to attach is heightened when they experience multiple disruptions in life. "With each additional disruption, the ability to bond diminishes" (Alberta Children's Services Workforce Development and Gough, 2007, p.1). When child protection needs are serious children are often removed from their home and placed in foster care or kinship care. In an analysis of issues in Canada related to the placement of Aboriginal children in care, Gough, Trocme´, Brown, Knoke and Blackstock (2005) identify a disproportionate representation of these children in care. In particular, Gough et al. (2005) note that the numbers continue to rise despite the awareness of this concern and indicate that the placement of Aboriginal children in care is a critical question requiring ongoing discourse and research.

Cascading Vulnerabilities

Children with FASD have cascading vulnerabilities physically, emotionally, mentally and spiritually when they are not offered adequate supports within systems that are designed to protect them and provide developmental stability. When I searched the words "cascading vulnerabilities", a term which emerged from my reflections and research regarding children with FASD and their many struggles, I discovered this was an engineering term. The original meaning of this term relates to the potential of large scale failure of electrical systems when particular parts of the system are disrupted. The loss of power in one part of the system results in loss in other parts of the system which continue to build into large scale blackouts across the grid. This metaphor represents a challenge to develop models of practice that recognize the impact of loss for children with FASD and the need to build strong systems that will not fail them in their profound need for security and developmental stability whether at home or in care.

Children with FASD can have particular physical vulnerabilities such as developmental delays, neurobiological problems, physical problems such as heart disease, musculo-skeletal problems and compromised immune systems (Stratton, Battaglia and Howe, 1996). However, the greatest challenge children often face is societal misunderstanding and stigma related to a disability whose cause lies in intergenerational struggle within family systems. The social construction of knowledge about FASD emerges from a society which values perfection and does not easily abide difference, thus contributing to a failure to recognize the unique and sacred nature of each person in the world. Children with FASD are at high risk of abuse, a lack of understanding regarding neurobehavioral problems and are particularly vulnerable to those who would take advantage. One of their greatest vulnerabilities is societal perception of who they are based on media representation of individuals with FASD as more likely to be engaged in criminal activity and a danger to self and others. More recently Sullivan (2009) focuses on underlying vulnerabilities and problems in life adaptations including "poor parental role modeling, disturbed development of trust and identity, patterns of avoidant coping behaviour, dysfunctional adolescent and adult relationships, and economic disadvantage" (p. 226). These concerns are realities for adults with FASD and indeed pose challenges because intervention aimed at ameliorating these concerns is time-intensive and costly. A small literature is beginning to appear that focuses on the quality of life of individuals living with FASD that may provide a fuller picture of what it means to live with FASD and how we can improve the quality of life for children, adolescents and adults (Stade et al. 2006;Grant et al., 2005).

Service Delivery

Services delivered to children in care are largely determined by the assigned caseworker with guidance from a casework supervisor and existing policies. The competence of the worker and their knowledge about FASD will influence their choice of services accessed for children. At present there are no formal measurements of the level of knowledge of caseworkers regarding FASD. In this project, all workers and caregivers within the pilot project received training specific to the standards. A total of 1932 training hours were logged over the duration of the

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two year project.

An Eco-Map for a child with FASD in care could include some of the following needs as determined by the caseworker: caregiving system (foster care, youth and child care network); adequate funding for support services and community involvement; youth justice network; education; medical care including access to other health professions such as services offered by a psychologist, occupational therapy, physiotherapy, speech therapy; disability accommodations as required; transitional planning; and finally a social life which includes a connection to family if possible including immediate or extended family members. Concerns raised in the focus groups with foster parents were tensions regarding the issue of family visitation. Although it may be controversial to raise this concern, its identification within the practice standard identified as Home Visits is important in the interest of best practice.

The standard on Home Visits required caseworkers to complete a family visitation checklist and a family visitation plan. The rationale identified in the standards regarding this planning is that it is important to anticipate the potential benefits and detriments of familial contact. Dependent on the circumstances related to how the child came into care, the relationship between the family and the agency and ongoing protection concerns, it is recognized that this is a sensitive issue. A standard was identified to ensure that the child derived benefit from the visit as well as the family. It was also believed that structure around the visits was important including time, location and supports required. The concerns identified regarding the visits were that they affect the routine, attachments and bonds in the foster home. An internal conflict for children is that they do not want to leave their biological family, or their foster family. Another concern identified related to the grief children experienced after a family visit and that it sometimes took several days to re-establish a routine post family visitations. When families did not show up for scheduled visits this also created considerable distress for children.

It is important to recognize that visiting their children who have been removed from their care is often a painful experience for parents. There needs to be a sensitivity protocol established for interacting with biological families by the child welfare system. It is important for caseworkers to use caution in how information on alcohol consumption is gathered as this can trigger overwhelming guilt and grief responses that constitute a risk for women. Research on birth mothers of children with FASD unequivocally identifies the need for a woman centered approach in working with families (Poole and Greaves (2009) Badry, (2009); Boyd and Marcellus (2007), Poole (2003), Grant, Ernst, Streissguth and Stark,(2005) Greaves et al. (2002), Lesichner (2001) Rutman, Callahan, Lundquist, Jackson & Field (2000). Dell and Roberts (2005) suggest greater efforts be made on the part of professionals in terms of their knowledge and preparation to care for women who are dependent/misusing alcohol. In raising this issue it is important to consider how best to intervene with families and ameliorate these concerns. The seriousness of child protection concerns must not be minimized. However, utilizing an approach that does alienate families is also crucial. The disruption of the parent/child bond through the placement of children in care influences attachment and can lead to later problems in development (Alberta Children's Services Workforce Development and Gough, 2007). Wherever possible, these disruptions should be minimized. Providing connections and anchors for the child or young person in care to their community on a regular basis, in the presence or absence of their parent(s) can offer security to children and families. Neckoway, Brownlee and Castellan (2007) raised the question of Aboriginal parenting realities relevant to attachment theory and support the need for considering the role of extended family and kin. Perhaps healthy attachment between child and community may mediate some of the difficulties identified regarding family visitation.

If visits are perceived as disruptive this notion needs to be challenged as policy requires they occur unless they have been discontinued based on a court order such as permanent guardianship. Creative ways of involving children with the community such as monthly community days may be considered as a way to keep children connected to their relatives and identity in the absence of parents. Engaging in "community" visitation on a regular basis versus individual family members may offer consistent support to children, families and the community as a whole, and minimize the discourse of disruption around the process of visitation. Children with FASD need routine, structure and consistency. Addressing family visitation from a position that involves the community may be an important consideration for future practice. This approach supports the child, the family and the community to stay connected. Finally, this issue needs to be addressed from a holistic and ecological perspective with various stakeholders in order to bring resolution to these concerns while keeping children linked to their communities on a regular basis.

FASD Practice Standards Research

At the beginning of the implementation and evaluation of the FASD Practice Standards project, researchers and caseworkers believed that this was critical social science research that must be done. Awareness of increasing numbers of children in care with suspected or diagnosed incidence of FASD is a burgeoning concern. Our research employed both qualitative and quantitative methodologies. There were 33 children in the pilot group and 30 in the control group

in relation to the casework standards. Changing casework practice required a paradigm shift and the implementation of a new model of practice was identified as an important phenomenon to study. Focus groups were held separately with caseworkers and foster parents to develop an understanding of the experience of this process. The underlying research question was whether the standards made a difference in outcomes for children in care with FASD.

One of the issues raised by the team developing and initiating the standards was the concept of what constitutes being a "good guardian" for children in care with FASD. It was recognized within the development of the standards that the guardianship of children with FASD was complex, and required additional intervention and support by caseworkers. The construct of improving care was worthy of attention in this research. The commitment to offering more casework hours for children at a multiplier of 1.5 was critical to the success of the project. Additional staff was hired in order to decrease caseloads and support increased time for the worker in terms of face to face contact, visitation to the foster home and completing required documentation.

The research included focus group discussions with staff and foster parents in the pilot region at the beginning, mid-point and end of pilot implementation as well as case reviews to determine the level of compliance with the practice standards. Second, for the purposes of hypothesis testing, a quasi-experimental matched comparison group design was utilized involving a pilot group that implemented the Practice Standards, and a comparison group, which did not. Children included in this study were matched based upon age, gender, child welfare status, number of years in foster care and diagnostic classification (i.e. diagnosed or suspected). An assumption was made that children identified for assessment of FASD should be included within the study as they were likely to receive benefit from being involved.

In creating the measurement instrument, decisions were made to monitor behaviors that were of concern to the caseworkers including, self-harm, drug and alcohol misuse, AWOL (absence without leave) and involvement in criminal activity. These concerns were previously identified in the research literature by Streissguth (1997) as secondary disabilities. In addition to designing instrumentation to measure these problems, along with time logs for case managers. Each form of risk behaviour demonstrated a downward trend over the duration of the implementation of the practice standards with the steepest decrease for criminal behaviour and drug use.

The casework standards were designed to offer early identification of FASD through screening and referral, planning for specific needs of children based on assessment/diagnosis, increased training on FASD for caseworkers, foster parents and community based program staff. Program standards were developed in foster care, kinship care, adoption, private guardianship, residential care, family preservation and youth mentoring services. Desired outcomes included increased placement stability, decreased incidences of behavioral problems and risk behaviors, as well as effective transition to adult services, including the completion of transitional plans to adulthood by age 16.

To address the impact of the Practice Standards, this project examined three major outcomes within the Aboriginal unit: residential placement stability, quality of relationships with caregivers and teachers, and risk behaviours. There were no statistically significant differences in relation to gender, diagnostic classification and age between the Pilot (Lethbridge, Alberta and area) and Comparison groups (Calgary, Alberta). However, the Comparison group had a much higher proportion of PGO status cases than did the Pilot group. While the Pilot group experienced higher rates of placement change before and during implementation of the Practice Standards, there was a significant decrease in placement changes over time resulting in a convergence of mean placement changes over time. Consistent patterns of reduced risk behaviors and school absences were associated with the implementation of the Practice Standards. Despite a trend of decreasing respite care during the implementation phase, mean ratings of the perceived quality of relationships at home and school as well as self-reported placement satisfaction increased during the implementation of the Practice Standards.

Diagnosis of FASD

The issue of diagnosis of FASD emerged as an important phenomenon though the research based on information retrieved in focus groups. The origins of FASD emerge from the medical model (Jones and Smith, 1973; Lemoine, 1968). From a medical paradigm the issue of diagnosis is critical in terms of responding to an illness or chronic medical condition. It is important in relation to the FASD that child welfare and the medical profession work collaboratively in terms of assessment and diagnosis. It is not possible to engage in a discussion of diagnostic terminology in the context of this paper as this is an extensive topic and at times controversial.

Children with suspected or diagnosed FASD often come to the attention of child welfare due to the issues of substance misuse in their homes. The issue of how children became aware of their diagnosis of FASD came to our attention through the focus groups. Although both the child welfare and medical system support the importance of a diagnosis in mediating the concerns and needs for children with disabilities as a result of alcohol exposure in utero, some children experience grief when discovering they have received a diagnosis of FASD. In deconstructing this issue it is important to consider the implications of a diagnosis

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for a child. Some children reacted to this news by being offended, angry about being labeled and had difficulty understanding the meaning of the diagnosis.

A practice standard identified as Child and Family Awareness of FASD suggests that receiving a diagnosis will help children and families to receive support in dealing with barriers and problems they face. Foster parents indicated that not all children are ready to hear about the diagnosis and this information sometimes leads to negative changes and turmoil within the child. Children have also "shutdown" after hearing this information and some experience depression. The information provided to biological families must be presented by the caseworker and it was acknowledged that this was a challenging task. It was discovered that children receive information about a diagnosis of FASD from several different sources including medical professionals, caseworkers and foster parents. Children are challenged to meaningfully interpret what this diagnosis means and it was suggested as a result of this research that a protocol for disclosure of FASD to children must be developed in child welfare practice.

There are many issues that require further exploration as a result of reviewing the data generated from both qualitative and quantitative data. It is important to note that despite the challenges of implementing enhanced standards of care for children with FASD, the commitment to this project from a regional perspective was profound. Further, it must be stated that enhanced supports for children with FASD are important. Our research supports the case that some specialization in the delivery of child welfare services is required for this population. It must be noted that this evaluation contributed to greater awareness of the many activities which caseworkers and foster parents engage in to support children with FASD. It also provided an opportunity for these groups to reflect on their experiences in caring for children with complex needs, and offers important insight that can inform future practice.

Key Findings

- While the Pilot group experienced higher rates of placement change before and during implementation of the Practice Standards, there was a significant decrease in placement changes over time resulting in a convergence of mean placement changes over time.
- Consistent patterns of reduced risk behaviors and school absences were associated with the implementation of the Practice Standards.
- Specific training in FASD supports caseworkers and foster parents in working with children and in meeting their needs more effectively. Training opportunities are valued and more specialized training is required.
- Caseworkers and foster parents were invested in the application of the standards, valued the experience, and the opportunity to reflect on their practice.
- Family visitation is a major site of conflict and tension, and considered to be the biggest factor in the "disruption" of the life of the child by foster families.
- The application of standards appeared to minimize other life disruptions such as school absences, behavioral difficulties, and change of placement.
- The diagnosis of FASD impacts the emotional well being of the child and leads to a key recommendation that a protocol for disclosure of FASD to children and families should be jointly established between diagnostic clinics and child welfare agencies.
- The use of respite should be negotiated with foster families.
- The standards state that there should be a minimum of two children with FASD in a home, and this is a source of conflict for some foster families.

Conclusions

The topic of FAS/FASD is phenomenon of great interest to many sectors in the professional world such as medical doctors, social workers, nurses, psychologists, occupational therapists, counselors, youth and childcare workers, foster parents, community and government professionals. The FASD Practice Standards research that took place between 2003-2005 yielded valuable information in regards to child welfare practice for children with FASD in care. As a result of this research, awareness of the complexity of children in care with FASD was examined and the final recommendations of this study are important to highlight in conclusion.

Training on the complexity of fostering and engaging in casework for children diagnosed with FASD should be ongoing with particular focus on different issues at different ages (early childhood/pre-school, school age, and adolescence, young adulthood). Given the complex needs of children with FASD a recommendation was made that no more than two children with FASD be placed in one foster home, to support the long term stability of the placement. However, in the case of sibling groups this may not be in the children's best interest and may require a flexible response. It is important to take a long term perspective if children are in permanent care and there needs to be awareness and consideration regarding the ability of foster parents to effectively meet the needs of more than two children with FASD.

The disclosure of FASD to a child has huge implications in their lives. The child must deal with being diagnosed with a disability, the history of their family, the societal biases which are inherent in a diagnosis, and the child's own

concern about what this means. One standard addresses family awareness of FASD, but there is not consensus on how much information needs to be provided to a child. The impact of a diagnosis requires a specific set of supports and guidelines that address the experiences of trauma and grief which can emerge subsequent to learning this information. A recommendation was also made that Children's Services undertake a dialogue aimed at addressing the issue of family contact and visitation from a holistic, ecological perspective to diminish its emergence as a serious site of conflict for everyone involved.

A final recommendation made in 2005 at the conclusion of this project was that the FASD Practice Standards be implemented in other regions. This research demonstrated positive results for children, families, caseworkers and foster parents. Focusing the spotlight on specialized practice in FASD and systemic responses to this issue highlighted a worthwhile effort on the part of Alberta Children's Services to deliver services in a new way. The research also highlighted areas of concern such as conflict over the issue of visitation, a topic that merits further work. A common concern related to best practice for children with FASD emerged as a result of this project and dialogue was generated about the need to practice differently by offering increased hours of service. The benefit of offering specific training assured that everyone involved in the project received the same information, thus increasing the possibility of a consistent response to children.

Finally, in December, 2009, Alberta Children's Services announced that the FASD Practice Standards project would be expanded to four Child and Family Service Authorities based on the success of the earlier pilot. The four regions include the initial pilot site in Region 1 (Southern Alberta), Region 7 which encompasses a very large geographic area from Lloydminster to Jasper, Region 9 – Fort McMurray and Region 10- Land Based Métis Settlements. The inception and initiation of new models of practice in the delivery of child welfare services is a worthwhile endeavour. It is anticipated that growing awareness of the complex needs of children with FASD and responses grounded in innovative practice will better serve children.

References

Alberta children's Services Workforce Development & Gough, P. (2007). *Supporting healthy attachment: An overview for child welfare practitioners*. CECW Information Sheet #56E, Retrieved online November 8 from http://www.cecw-cepb.ca/.

Armstrong, E. (2003). C*onceiving risk, bearing responsibility: Fetal alcohol syndrome & the diagnosis of moral disorder.* Baltimore: John Hopkins University Press.

Armstrong, E. & Abel, E. (2000). Fetal Alcohol Syndrome: The origins of moral panic. *Alcohol and Alcoholism* 35, (3) 276-282.

Aronson, M. (1997). Children of alcoholic mothers: results from Goteborg, Sweden. In. Streissguth, A.P. and Kanter, J. (Ed.), *The challenge of fetal alcohol syndrome: overcoming secondary disabilities* (pp. 15-24). Seattle: University of Washington Press.

Badry, D. (2009). *Becoming a Birth Mother of a Child with Fetal Alcohol Syndrome*. Unpublished Dissertation, Graduate Division of Educational Research, University of Calgary.

Badry, D. & Pelech, W. and Norman (2005). F*etal Alcohol Spectrum Disorder Practice Standards Evaluation Project Final Report*. Alberta Children's Services.

Barr, H., & Streissguth.A. (February 2001). Identifying maternal self-reported alcohol use associated with Fetal Alcohol Spectrum Disorder. *Alcoholism: Clinical and Experimental Research*, 25(2), 283-287.

Berube, M. (2005). *Modern lepers: From person to political, prevention of FASD through working with marginalized women*. Unpublished master's case-study, Faculty of Social Work, University of Calgary, Calgary, Alberta.

Boyd, S. (2004). *From Witches to Crack Moms: Women, Drug Law and Policy*. Durham, North Carolina: Carolina Academic Press.

Boyd, S. & Marcellus., L. (2007). *With child: substance use during pregnancy. A woman centred approach*. Halifax: Fernwood Publishing.

Chudley, Albert E., et al. "Fetal Alcohol Spectrum Disorder: Canadian guidelines for diagnosis." *Canadian Medical Association Journal*, 172.5 Suppl (2005): S1-S21.

Clarren, S.K. and Lutke, J. Building clinical capacity for Fetal Alcohol Spectrum Disorder diagnoses in Western and Northern Canada. *Canadian Journal of Clinical Pharmacology* (2009)15, 2: e223-e237.

Dell, C. & Roberts, G. (2005). *Research Update: Alcohol use and pregnancy: An important Canadian public health and social issue.* Public Health Agency of Canada.

Fetal Alcohol Spectrum Disorder Practice Standards. (2003). Southwest Alberta Child and Family Services, Alberta Children's Services.

Ferguson, L. (1997). *Deconstructing Fetal Alcohol Syndrome: A critical inquiry into the discourse around alcohol, women, ethnicity, Aboriginals and disease*. (Unpublished Masters thesis, Carleton University, Ottawa, Ontario).

Fuchs, D., Burnside, L., Marchenski, S. and Mudry, A. (2005). *Children with disabilities receiving services from child welfare agencies in Manitoba*. Winnipeg, MB: Centre of Excellence for Child Welfare. Retrieved online from http://www.cecw-cepb.ca.

Gearing, R., McNeill, T. & Lozier, F. (2005). Father involvement and fetal alcohol spectrum disorder: developing best practices. *Journal of FAS International*, Article 3e14, Retrieved online October 12, 2007 from http://www.motherisk.org/FAR/

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econtent_archives.jsp?archive_id=5.

Gough, P. (2006). *Alberta's child welfare system. CECW Information Sheet #46E*. Retrieved October 20, 2009, 2009, from www.cecw-cepb.ca.

Gough, P., Trocme´, N., Brown, I., Knoke, D. & Blackstock, C. (2006). *Pathway to the overrepresentation of Aboriginal children in care. CECW Information Sheet #23E*. Retrieved October 20, 2009, 2009, from www.cecw-cepb.ca.

Grant, T., Ernst, C., Streissguth, A., & Stark, K. (2005). Preventing alcohol and drug exposed births in Washington State: intervention findings from three parent-child assistance program sites [Electronic Version]. *The American Journal of Drug and Alcohol Abuse*, 31, 471-490. Retrieved March 16, 2007.

Hutson, J. (2004). "Meconium Fatty Acid Ethyl Esters and Predictions of Fetal Alcohol Effects." *Journal of Fetal Alcohol Syndrome International*, 4: e15-e18.

Jones, K. L., Smith, D., Ulleland, C., & Streissguth, A. (1973). Patter of malformation in offspring of chronic alcoholic mothers. *The Lancet*, 1267-1271.

Lemoine, P. (2003). The history of alcoholic fetopathies. *Journal of FAS International*,4, Article 1e2, Retrieved online October 12, 2007 from http://www.motherisk.org/FAR/econtent_archives.jsp?archive_id=5.

Marsh, J., & Dingcai, C. (2005). Parents in substance abuse treatment: implications for child welfare practice [Electronic Version]. *Children and Youth Services Review*, 27, 1259-1278.

Neckoway, R., Brownlee, K. & Castellan, B. (2007). Is attachment theory consistent with aboriginal parenting realities? *First Peoples Child & Family Review*, 3(2), 56-64.

O'Malley, K. (Ed.) (2009). *ADHD and fetal alcohol spectrum disorders (FASD)*. New York: Nova Science Publishers.

Poole, N. (2003). *Mother and child reunion: Preventing fetal alcohol spectrum disorder by promoting women's health*. Vancouver, BC: Centre for Excellence in Women's Health.

Roy, C., Black, T., Trocmé, N., MacLaurin, B. & Fallon, B. (2005). *Child neglect in Canada. CECW Information Sheet #27E*. Retrieved online November 9, 2009 from http://www.cecw-cepb.ca.

Stade, B. C., Stevens, B., Ungar, W., Beyene,J. & Koren, G. (2006) "Health-Related Quality of Life of Canadian Children and Youth Prenatally Exposed to Alcohol." *Health and Quality of Life Outcomes* 4.81. Retrieved online November 9, 2009 from http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1617087.

Stratton, K., Howe, C. & Battaglia, F. (Eds.) (1996). *Fetal alcohol syndrome: Diagnosis, epidemiology, prevention and treatment*. Washington, D.C.:Institute of Medicine, National Academy Press.

Streissguth, A. (1997). *Fetal alcohol syndrome: A guide for families and communities*. Baltimore, MD: Brookes.

Streissguth, A.P. and Kanter, J. (Ed.), (1997). *The challenge of fetal alcohol syndrome: overcoming secondary disabilities* (pp. 15-24). Seattle: University of Washington Press.

Streissguth, A.P. & O'Malley, K. (2001). Neuropsychiatric implications and long-term consequences of fetal alcohol spectrum disorders. Retrieved online from *MEDLINE*. ISSN: 1084-3612.

Sullivan, A. (2009). "Fetal alcohol spectrum disorders (FASD) in the adult: Vulnerability, disability, or diagnosis – a psychodynamic perspective." In O'Malley, K. (Ed.). *ADHD and Fetal Alcohol Spectrum Disorders (FASD)*. New York: Nova Science Publishers. (pp. 215-245).

Tait, C. (2000a). *A study of the service needs of pregnant addicted women in Manitoba*. Manitoba Health: Prairie Women's Health Centre for Excellence.

Tait, C. (2000b). *Aboriginal identity and the construction of Fetal Alcohol Syndrome. Montreal, Quebec: Proceedings of the Advanced Study Institute: The Mental Health of Indigenous Peoples*. Culture and Mental Health Research Unit Report No. 10. Retrieved February 2, 2003 from http://www.mcgill.ca/psychiatry/transcultural/pdf/Report10.pdf.

Tait, C. (2003a). *Fetal Alcohol Syndrome among Aboriginal people in Canada: Review and analysis of the intergenerational links to residential schools*. Montreal, Quebec: The Baronial Healing Foundation.

Tait, C. (2003b). *The tip of the iceberg": The "making" of fetal alcohol syndrome in Canada*. Doctoral Dissertation, McGill University, Montreal, Quebec. Retrieved October 14, 2007 from http://www.mcgill.ca/files/namhr/Tait-2003.pdf.

First Peoples Child & Family Review
A Journal on Innovation and Best Practices in Aboriginal Child Welfare Administration, Research, Policy & Practice
Volume 4, Number 1, 2009, pp. 57-65

One Indigenous Academic's Evolution: A Personal Narrative of Native Health Research and Competing Ways of Knowing

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Abstract

Indigenous health research should reflect the needs and benefits of the participants and their community as well as academic and practitioner interests. The research relationship can be viewed as co-constructed by researchers, participants, and communities, but this nature often goes unrecognized because it is confined by the limits of Western epistemology. Dominant Western knowledge systems assume an objective reality or truth that does not support multiple or subjective realities, especially knowledge in which culture or context is important, such as in Indigenous ways of knowing. Alternatives and critiques of the current academic system of research could come from Native conceptualizations and philosophies, such as Indigenous ways of knowing and Indigenous protocols, which are increasingly becoming more prominent both Native and non-Native societies. This paper contains a narrative account by an Indigenous researcher of her personal experience of the significant events of her doctoral research, which examined the narratives of Native Canadian counselors' understanding of traditional and contemporary mental health and healing. As a result of this narrative, it is understood that research with Indigenous communities requires a different paradigm than has been historically offered by academic researchers. Research methodologies employed in Native contexts must come from Indigenous values and philosophies for a number of important reasons and with consequences that impact both the practice of research itself and the general validity of research results. In conclusion, Indigenous ways of knowing can form a new basis for understanding contemporary health research with Indigenous peoples and contribute to the evolution of Indigenous academics and research methodologies in both Western academic and Native community contexts.

End of an Era, Beginning of a Career

As part of my 2007 doctoral research in counseling psychology at the University of Victoria in British Columbia, I carried out a community-based project with an Indigenous social service agency in a small western Canadian city. The research question was: How do Native counsellors understand the intersection of traditional Indigenous cultural conceptions of mental health and contemporary counselling practice? Through my dissertation, I attempted to answer this research question by articulating Indigenous community perspectives on mental health and healing. I structured and conducted a qualitative study using a narrative methodology that was based on a conceptual framework of Indigenous ways of knowing and social constructivism. I in-depthly interviewed five Native counsellors using a set of narrative questions to get their stories about the intersection of Indigenous mental health and healing with their counselling practices. A narrative analysis of the interviews, using a story map, yielded within and across participant results. Core concepts of cultural identity, community, holistic approach, and interdependence were presented as the final results to construct an illustration for Indigenous healing and counseling. This counseling illustration epitomizes a goal of this study, in that it is a concrete articulation that can be used to influence education, counselling and other mental health services, and, importantly, government policy. From an Indigenous perspective, these core concepts of community, cultural identity, holistic approach, and interdependence must be actively present in the process of counselling and healing. It has been suggested in the literature that elements such as these are present in the context of Native mental health; the voices of the participants in this study carry these statements one step further by asserting their necessity and integrity to mental health and healing. The counsellors interviewed had knowledge and experience in the practice of helping relationships, and by virtue of their own cultural identities as diverse Indigenous peoples. Their stories represent authentic experiences of mental health and healing in their work as

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professional helpers over past and present experiences and future intentions and by extension give relevance and strength to this research.

Completing this project marked the end of my studies as a graduate student at a major Canadian university. The date of my successful defense of the dissertation signaled a stop to many hoops I'd had to jump through, metaphorically speaking, to reach my goal of becoming both a professor and Indigenous psychologist, where I had always imagined myself to be free from the oppressive arm of Western ways of being and doing. Yet my learning as Indigenous scholar and practitioner was just beginning. This paper details a narrative account of my process of development as a researcher through discussion of issues of research positions, western constructs of bias and generalizability, Indigenous ways of knowing, and new possibilities for reconciling Western and Native knowledge systems in the academy. I conclude with suggestions for other Indigenous academics and future directions for research

Research Positions

Researcher

I am from the Yellowknife Dene First Nation (Northwest Territories, Canada), am a member of the urban Aboriginal community where I attended university, and have formed both personal and professional contacts with various local, out of province, and national Aboriginal organizations and groups, including those who agreed to be involved in this study. Firstly, I had obtained preliminary and on-going consent from the First Nations band office in the territory. Secondly, a Native community agency that delivers mental health support had agreed to collaborate with me to conduct this research. Thus from the agency I received consent from my consultant who is in a management position, the Executive Director, and the individual participants who are front line mental health workers. It must be noted that following Native protocol as laid out by Dr. Clare Brant's Native Rules of Behaviour (1990) and the British Columbia Aboriginal Capacity and Developmental Research Environment's (BC ACADRE, 1995) four R's of Aboriginal Health Research (Respect, Reciprocity, Relevance, and Responsibility) the were very important to me through the entire research process, and even beyond the end of the project. Even once this project was competed, I remained, and continue to be, committed toward giving back to the communities that shared their stories and resources with me. Giving back to the community for me as a researcher includes volunteering my own service as a professional counsellor to the community as a whole so that they can meet their members' needs, assisting the Band offices with funding proposals and research protocols, and helping organize the youth sports events that occur in the local Native community.

My own interests in mental health and healing stem from a long familiar history of helping; my grandfather was a healing drummer in our community until he passed away in 1997, and there are many generations of helpers and healers in my family tree on both my father's and mother's sides of the family. I had naturally assumed both formal and informal helper roles throughout my life. For my family, and in many Native communities across Canada (I came to learn), that helping others is a strong cultural value. When I entered university as a student in the 1990s, it was with the express purpose of gaining education in the formal helping field so that I could work within the Native context as a mental health professional to deal with the devastation of colonialism that had rocked my own life and that of those in my family and wider communities. I had not anticipated, at the time, that much of the healing journey would be about me, and my development not only as a psychologist but an academic.

Research Participants

The specific site of the study was a Native owned and operated community agency in a medium-sized Western Canadian city, whose mandate is to meet the social and health needs of urban Native peoples from both western health care services and localized and traditional Indigenous cultural perspective. The agency employs over 50 staff members ranging from administrative staff to clinical and employment counsellors, social workers, and youth and child development support workers and runs dozens of individual and group programmes for Native peoples from diverse cultural backgrounds. Traditionally, the medium sized city in which the agency is located Coast Salish territory, currently with intersections of a number of other First Nations and Métis peoples. The provincial Aboriginal population is about 170,000, or about 17% of the total Aboriginal population in Canada (Statistics Canada, 2003). Provincial statistics (British Colombia Statistics, 2003) reported in 2001 that in this particular city in which the study took place, there were 8700 individuals identified as having Aboriginal ancestry, comprising 4185 males, and 4510 females.

Participants were recruited through professional connections at a Native community agency where I had a previously established relationship with staff and administration prior to the implementation of the research project. This previously established relationship was as a result of a role I had served as a consultant and liaison for the agency regarding University of Victoria counselling programming and research collaborations. Recruitment occurred through letters that I distributed to individual mailboxes of all of the workers at the agency. I also hosted an informal information session at the agency during their lunch break, where I invited all staff to attend in order to meet me and learn about my research project, and at

that time I also handed out recruitment letters and invited possible participants to contact me for more information.

Participants were individuals of self-identified Indigenous ancestry who worked in a counselling or support capacity with Native clients at the agency. All of the mental health workers at the agency were of Indigenous ancestry. Five participants were interviewed from the pool of available mental health workers. Participants had some post-secondary education in Western approaches to counselling, with training from at least one of the following disciplines: social work, counselling, psychology, and child and youth care. Participants had been employed for several years as a counsellor, and the range of experience was from 3 to 15 years; this requirement ensured that participants had more than short-term experience as mental health workers. "Selection of informants rest more on the careful identification of persons, often in advance, who are representative of the culture and show potential to reveal substantive data on the domain of inquiry" (Leninger, 1985, p. 47).

When Worlds Collide: Indigenous Research in the Academy

There are conflicts inherent to a meeting of two minds, such as Western thinkers and Indigenous ways of being and knowing. Some of the most salient conflicts of this nature that occurred in my experience of the study are summarized below as issues relating to bias, generalizability, and Indigenous ways of knowing. It must also be noted that as in all qualitative studies, there are particular limits a study can have regarding the degree of facts and interpretations that can be drawn from it. These types of conflict are not novel to Indigenous-Western relations, nor to any system that has opposed Western domination in the form of cognitive imperialism. In fact, Indigenous knowledge has historically received a tepid welcome (at best) from Western learneds, whose sole mission, until recently, has been to colonize Native peoples (thinking and all). Moving forward to reclaim Indigenous identity through knowledge systems is one way to recover from this historical and on-going colonial experience. "The reach of imperialism into 'our heads'" challenges those who belong to colonized communities to understand how this occurs, partly because we perceive a need to decolonize out minds, to recover ourselves, to claim a space in which to develop a sense of authentic humanity" (Smith, 1999, p 23).

Bias

Researcher bias often arises as a concern for qualitative researchers. Further, qualitative research is methodologically based on intersubjectivity, which is, not based on attempts at objectivity that are central to quantitative methodologies. Gadamer (1994) asserts that qualitative researchers must put research protocols into place to address this as a concern of rigor and validity. According to Schwandt (1997) there are several types of bias in research: 1. Bias due to over-reliance on central informants; 2. Selective attention to specific or salient events; 3. Bias due to the researcher being in the field/location of research; and 4. Bias due to the participants being interviewed at the site of the research. However, these four points of bias could (depending on the paradigm), instead, be considered as part of the research experience as a non-objective, or non-operational event. For my project bias became a part of the process in the form of using my field journal and field notes as sources of data. Thus I was embracing the notion of bias as a valuable part of both the process and data analysis, instead of trying to ignore or control the level of bias that existed. Much of the critique of qualitative research in general in terms of bias does not take into account the nature of qualitative research as intersubjectivity and its methods, such as purposeful sampling or the principle that the researcher is a primary instrument of the research (Denzin & Lincoln, 2000; Taylor & Bogden, 1984). Also ignored by critics of qualitative research are the political and socio-cultural discourses involved in the theory and practice of social science that questions research objectivity in research practice (Schwandt, 1997). This is a particularly relevant point when considering research in Indigenous contexts. In this way, my research can be in danger of being subsumed by the historical academic debate between the validity and rigor of qualitative versus quantitative paradigms, whose values and philosophies, much like Indigenous and Western respectively, hold values and beliefs that are very different. Thus there could be parallel drawn alongside the tensions between qualitative and quantitative methodologies and Indigenous and Western worldviews in the context of research.

Gadamer (1994) writes that bias cannot be eliminated or placed aside in any research method. No researcher can avoid bias through selection of method; all people interact with some level of bias as a matter of natural human thinking and behaviour. Gadamer asserts that bias is an inseparable part of the human condition. Bias is a fact of life that we as human beings at times depend on to give us an understanding to a situation. For my research, bias, or previous experience and knowledges stemming from own position, became a value part of the process. Yet an important facet to this understanding may lie in the goodness or adversity of how we employ a bias. Schwandt (1997) agrees with this view of bias by stating, "In fact, our understanding of ourselves and our world depends on having prejudgment. What we must do to achieve understanding is to reflect on prejudice [as bias] and distinguish enabling from disabling prejudice" (p. 10). For example, my personal history as a colonized Dene woman and my own cultural clashes with Western knowledge with

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in the academy provided me with useful insight in to the results and implications of this study.

I am aware of my biases with respect to this research, and in order to understand and reflect on these, I have framed them as assumptions. In Indigenous ways of knowing, assumption and beliefs from the basis to legitimate knowledge that is grounded in the reality of the individual and their own experiences (Erasmus & Ensign, 1998). Thus assumptions became a part of Indigenous research methodology, where relationship among people can viewed as a methodology (Barton, 2004). In a western construct, however, these relational assumptions would be viewed as biases. The following three assumptions underpinned the study:

1. Indigenous health research should reflect the needs and benefits of the participants and their community as well as academic and applied interests. It is my view that contemporary researcher practices should be constantly evolving, and that despite theoretical limitations, all should seek breaks with traditional-colonial theorizing about participants and communities, particularly Indigenous communities. The research relationship is one of a co-constructed nature (Peavy, 1998), but this nature often goes unrecognized because it is confined by the edges of a Western paradigm of ethical research and design practices (Piquemal, 2001). Alternatives and critiques of the current Western system of research must, from my position as a scholar, come from Indigenous conceptualizations and philosophies, such as Indigenous ways of knowing and Indigenous protocols.
2. An important assumption is that the participants would be willing to engage in honest and meaningful conversation with me about their experiences of mental health and healing in counselling contexts. Trust is the foundation of an ethical and authentic research relationship (Piquemal, 2001), and this notion of trust assumes that all parties involved will be honest in their interactions. It is my belief that trust was established between myself and the participants and other community members who gave input throughout the research process. Further, to consider a relationship that is founded on trust, there is an open possibility that this relationship is multifaceted, that it encompasses more than soley the research relationship. For the community agency to trust me enough to partner with me to carry out the research, I had to establish other professional and personal relationships with both the agency itself as an institution and the individuals who worked within it. Thus, what is considered a dual relationship in Western ethical codes of research and counseling could be viewed as both necessary and ethical in Indigenous protocols of research, and possibility helping relationships. This is an area that warrants further exploration in field of counseling research and research ethics.
3. I assume that there are important and wide differences between Indigenous and Western ways of helping and healing. As an Indigenous person, my worldview is very much biased from my experiences as a marginalized person in a Western world. As discussed above, these biases, or assumptions, hold a valuable insight for me as an Indigenous researcher in terms of understanding the context and what is important about it for Indigenous ways of knowing and mental health. Yet it is also valuable for me to remember, particularly in the context of research, that despite specific and cultural differences, we are all human beings that have the same goal of wellness and survival.

Further, despite varying epistemologies and paradigms, most peoples, regardless of cultural differences, share values of family, faith, belonging, and health. My personal and professional assumptions that Indigenous views of health or Indigenous ways of knowing are radically different from Western ways must be kept in the context of my experience and that of specific research questions posed for this study.

Generalizability

Generalizability is a concept from the quantitative paradigm that does not directly apply to qualitative research; generalizing results from a study of a population sample to a broader population is often viewed as the goal of [Western] scientific research (Creswell, 2005). However, it is worth discussion because in academic contexts it continually charges a debate on rigorous research of all kinds, and by extension, legitimate knowledge. In contrast, the utility of qualitative results are intended to allow the reader to understand the findings both within the context of the study itself and beyond. There are within and between group cultural differences amongst Indigenous Nations, individuals, and communities (McCormick, 1997). The issues and implications of this study were designed to enhance academic knowledge about cultural differences and to guide researchers to be sensitive to the mental health and healing needs of Indigenous peoples. The intent is to provide academic researchers with direction for cross-cultural sensitivities about mental health and healing that are respectful, synergetic, and aimed to benefit Indigenous communities at various levels. My methods of following local protocol, spending time in the community with the participants, consultants, Elders, and other community members, and my follow-though with give back to the community through dissemination and on-going relationship reflects a depth to this research. Thus the goal was not generate results that could be broadly applied

(generalized) to all Indigenous communities but instead to generate results that are valid and rigorous within the community where they were gathered. That is, if another researcher were to interview a similar pool of participants in the same setting, the results would be the same as mine.

Lincoln and Guba (1985) propose qualitative research as "naturalistic inquiry" for studies in the social and behavioural sciences because this type of inquiry would take into account the lack of predictability of human interactions and the unique lives outside of lab settings, and establish a separate set of criteria more appropriate to life outside the laboratory. Silverman (2001) found that in social contexts, qualitative research methods are believed to "provide a 'deeper' understanding of social phenomena than would be obtained from purely quantitative data" (p. 32). Qualitative methods usually devote large amounts of time to participants during the data-gathering phase, thus important and substantive information is obtained from those who are most affected by the issue of study (Schwandt, 1997). In Native communities, "people always do have ideas about what is best for their community" (Erasmus & Ensign 1998, p. 46). The direct input of Indigenous peoples regarding research in their own communities has been argued to be crucial in designing and implementing research of any methodology that yield authentic results because it is ethical in that it follows local protocol (Piquemal, 2001) not in its choice of research paradigm.

Qualitative or quantitative research can include the opportunity to involve the participants' community at all stages of the research process and thus be more hospitable to Indigenous ways of knowing. Partnerships can be developed with the community through their input in the planning, designing, data gathering and even analysis of the results (Hudson & Taylor-Henley, 2001). This process allows for meaningful input. Thus, the community becomes an important part of the research, rather than simply providing the data for research. Community members become invested in research activities and respond in a different way that has been viewed as deeper and more meaningful than in other research projects that may see them as subjects or objects of the research (Hudson & Taylor Henley, 2001). Participants can feel that the research belongs to them and their community. In fact, most Indigenous researchers consider participants as co-researchers and co-owners in the research results (Kenny, 2002). Given the history of misappropriation of Indigenous knowledge by researchers (Piquemal, 2001; Smith 1999), this approach helps to create a more respectful and receptive research context for all involved, as well as strengthen the internal validity of the study.

However, qualitative research has been described as seeking to understand how things happen, rather than what happens (Schwandt, 1997). Thus it is concerned with process. In this way, qualitative research is particularly suited to Indigenous communities, because in unearthing processes, there exits a possibility that the devastating results of colonization can be deconstructed (Kenny, 2002). The quandary of integrating traditional Indigenous and modern Western paradigms can be exposed. Then discussing and working toward understandings of such knowledge systems and how they fit with the quality of our overall health. Thus qualitative research goes beyond the surface and studies substance (Kenny, 2002), which for the purpose of this study, I assume can be valuable and meaningful beyond generalizable results.

Indigenous Ways of Knowing

Competing knowledge claims have existed through the ages and will continue to fuel debate. In Indigenous policy research, for example, the research is holistic and balanced, and the diverse positions on knowledge claims must all be considered in the context of ethical research practice (Erasmus & Ensign, 1998). Knowledge claims must be scrutinized for how they can best represent an Indigenous worldview, Indigenous systems of knowledge, and balance in a holistic perspective on policy research. It is critical to be aware that all sources of data derived from research in Native communities are ethically questionable if their methodology does not include appropriate attention to a Native cultural and social approach to contemporary research (Hudson & Taylor-Henley, 2001).

Traditional knowledge hinges on respect for all life forms as literally conscious and intrinsically interdependent and valuable (Corsiglia & Snively, 1997). Indigenous peoples' lives are characterized by a lengthy history of relations between community members, nonhumans (wild animals, insects, trees, rivers, grass, etc.), and lands (Gadgil, Berkes, & Folke, 1993). Escobar (1998) writes that "unlike modern constructions, with their strict separation between biophysical, human and supernatural worlds, local models in many non-Western contexts [like traditional ways of knowing] are often predicated on links of continuity between the three spheres and embedded in social relations that cannot be reduced to modern, capitalistic terms" (p. 61).

Each culture throughout the world has a set of paradigms, which are a collective set of values and knowledge of the way to live and be in the world (Lee, 1995). A distinction that may be made about Indigenous values is that they inform a body of knowledge about specific environments that span several thousands of years, in many cases since time immemorial (Kenny, 2002). Chief Wavey (1993, p. 11–12) notes that "we spend a great deal of our time, through all seasons of the year, traveling over, drinking, eating, smelling and living with the ecological system, which surrounds us" (p. 11). Indigenous peoples are

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characterized as having, for example, intimate knowledge of trap lines, waterways, spiritual/traditional lands as well as knowing their relationship to earth, which is expressed in cultural values such as sharing and caring (Escobar, 1998).

Colonization has interrupted many traditional ways of living and knowing for Natives throughout the world (Mussell, Nichols, & Adler, 1993). However, many Natives individuals and communities today are presently undergoing a profound spiritual renaissance of traditional ecological value renewal and Indigenous ways of knowing (Wenzel, 1997). This study reflects this return to traditional ways of knowing by its incorporation of community protocol and community consultation as part of its methodology, and the use of an Indigenous paradigm of health and healing. This study concludes with no suggestion of a definitive answer to general knowledge claims, as this was not a goal of the research, as discussed in an above section. My belief and intent is to offer alternative methods of legitimate researching and writing about Indigenous mental health and healing that is based in an Indigenous paradigm, or Indigenous ways of knowing. Perhaps this research is blazing the trail for Indigenous researcher to widen and further explore. My processes can serve as a successful example to create a definitive knowledge claim for Indigenous methodology that is grounded in community participation, local ethics, and Indigenous notions of relationship as the cornerstone for knowing, being, and doing for the purpose of rigor research.

Research Reflections: Walking the Line between Good and Evil

This study has been significant for me as a researcher in at least two ways. Firstly, I have learned that it is not always easy to go between the two worlds of Western academia and Indigenous communities. Secondly, carrying out research that benefits all involved is satisfying to me both personally and as a researcher.

In the course of my short academic career, going between the two worlds has been relatively smooth; however there have been some inevitable ups and downs. I strive to employ literature and data by Indigenous scholars and/or based in Indigenous methodologies, but this is not always possible or always easy. I have often been criticized from both Western and Indigenous colleagues about the use or exclusion of Indigenous and western sources of literature or data. That is, Indigenous scholars have berated me for not employing more or solely Indigenous sources of literature, while western scholars often do not see Indigenous sources as academically sound. Also, a negative aspect of this journey involves me being directly involved in academic research and suffering some confusion regarding my identities as Native person and a western-trained academic—two roles that have historically have come into conflict due to cognitive imperialism and unethical research practices. For example, when I am in a Native community, carrying out the process of western research as a graduate student representing a university, I am continually concerned about the ethical dimensions of the project—am I being respectful enough to the Native community? Am I following local protocol enough? Will any future aspect of this project that I may not currently foresee be harmful to the community? The list of questions that echoes in my internal dialogue is endless. There is a constant feeling within me that I must prove not only my research, but myself as an Indigenous person, to the community with whom I am working. Based on my interactions with community people involved in this project, there is little evidence to substantiate this feeling that I have -- it is perhaps more my own self-talk and personal history of experience that informs these emotions of self-doubt and fear. Oddly, the same emotions come over me when I am in the other world of academe. In a university environment I also feel that I must prove not only my research but myself as Indigenous person with a legitimate identity as such. The university is concerned with the rigour of my study, and this I anticipate. I often even enjoy the challenge of meeting this demand. Yet I have always felt somewhat emotional about justifying my identity as a Native person in the context of my research projects. Again, perhaps this fear and doubt comes from my personal history that is amply littered with experiences of racism, prejudice, and exclusion from the dominant Western society. However it is also true that some of these oppressive experiences have occurred within the context of post-secondary education. For example, in many graduate class I have had to answer specific questions for all Native peoples everywhere, been scapegoated by both other students and sometimes professors, to justify the colonial experience's effects on Indigenous health, education, and identity. Thus instead of fulfilling role as learner I have instead been forced into the position of one who corrects erroneous information and educates other students and some professors. What has been positive for me in the current research is the support and encouragement of my committee members, each of whom has inspired me to stay true to my voice as a Native person, and has fostered a sense of ability to incorporate this into my research in a way that is both systematic and true.

Carrying out research that is beneficial to both scholarship and to the community in which the research has occurred is satisfying. There have been times when my faith in the goodness of research has wavered, and this has disconcerted me, as I have been committed to seeking out and conducting ethical and successful scholarship since I began my studies. Having participant and other community members experience benefit from each stage of the

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research and from the results gives me a sense of pride and accomplishment in the work. I have not simply fulfilled part of doctoral requirements but I have done something that was of greater good for people within the context of the greater society. Further, I have addressed my own personal need to work toward healing and health in Native communities because my own family and personal history has been fraught with issues of unbalance and unmet healing needs due to the colonial experience. Contributing to the mental health and healing needs of Native communities is healing for me as a person who has been impacted by this history. Helping others is a strong value that I was taught by my grandparents and extended family that raised me from infancy. This project has strengthened my resolve to continue my effort to conduct ethical and appropriate community based mental health research with Native peoples. It inspires me to continue to seek out other people, both academics and native community members, to walk this path with me so we can continue to meet our peoples' health and healing needs.

There are many more ways in which this research has impacted my development as a researcher, however, the two ways discussed in this section have had the greatest effect on me. I will continue to learn and develop as researcher in ways that can bring me close to my Native culture and identity and further the field of researching cultural health in ways that benefit not harm those involved.

Resolution: A Changing Research Methodology

As discussed in an above section, it is my own belief (or bias) that research should be an evolving practice and that this practice develops through a process of praxis. Community-based research shares this view of being based on a process of praxis, where research methodology is refined and improved each time is implemented. My doctoral research contributed to the evolution of Indigenous community health research by giving a voice to Indigenous mental health workers in an academic context about their needs to be effective counsellors and the needs of their clients. Mental health services are largely delivered to Native communities by non-community members and from a non-Native paradigm. Giving voice to participants in terms of the topic of research, the analysis of results and the dissemination process strengthens the authenticity of the results and the methodology employed.

Indigenous peoples usually describe themselves as having an oral-based story telling tradition (Medicine-Eagle, 1989), thus a narrative approach is deemed culturally appropriate because it uses stories to elicit information; a narrative approach seeks the participants stories from their unique perspective (Tesch, 1990), and it is specifically the stories of Native mental health workers about their approaches and intentions toward health and healing that I sought. Narrative inquiry is also described as an academic research method of examination of metaphors, rituals, epiphanies, routines, and every day experiences, all of which are filled with culturally based complexities, hopes, and intentions (Mattingly & Lawlor, 2000). Another reason for using a narrative approach for this research question was the conception of narrative inquiry as a "relational methodology" when used in an Indigenous context, where epistemological implications of Native ways of knowing for academic interest, demonstrate how Indigenous epistemology can influence knowledge and practice in research (Barton, 2004, p. 519). In other words, narrative inquiry can be viewed as a way of incorporating Indigenous ways of knowing into the research process by, for example, using Indigenous epistemology such as storytelling as means of data collection or analysis. Barton (2004) also suggests that through the interpretive activities of both researchers and participants, the process of co-constructing and co-participating stories is inherent in a narrative inquiry, and this reveals a circular, or continual, understanding of experience. In this lies the strength of the contribution of my research.

Thus I relied heavily on Barton's (2004) understanding of narrative inquiry as a relational methodology for use with health research in Native communities, in which the research itself is based on the notion of relationship. My study employed a narrative methodology in the spirit of a collaborative relationship with an Indigenous community of mental health workers at a specific agency. As mentioned above, narratives have been shown in the literature to be an important part of traditional Native culture in term of its oral storytelling tradition. Further to this, it may now be possible to incorporate other Native traditions, such as Indigenous traditional ecological knowledge, which is based on a holistic conception of the world, into research methodologies.

Also in terms of research methodologies, this study shows how community-based research can be both ethical in terms of community protocols and rigorous in terms of academic standard. Training opportunities can be provided for communities involved in research, such as interviewing skills, developing questionnaires, surveys, or open-ended questions, setting up meeting schedules and presentation skills for dissemination. Community-driven research could thus promote the use of Indigenous expertise, both academic and traditional Native experts, throughout the research process (Whitmore, 1994).

A practical example of how this research could impact the health of Indigenous individuals is that counsellor training programmes for those working in Native communities could incorporate an Indigenous paradigm of mental health and healing into its curriculum.

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Specifically, traditional teachings in Native communities based on the medicine wheel create an epistemological paradigm that employs a holistic foundation for human behaviour and interaction; it informs a framework for mental health through a discussion of its four quadrants, each one a separate representation of an aspect of the self (Thunderbird, 2005).

Other Indigenous practices of healing and counselling mentioned by participants included:

- Storytelling
- Advice from Elders
- Interconnectedness with family and community
- Healing circles (round robin, usually started by an Elder)
- Ceremony (sweet grass use, vision quest, sweat lodge, prayer, drumming, sundance, and more)
- Incorporating food into the helping relationship
- Working with clients in nature (i.e. not in an office)

These practices usually include involvement with local community, including Elders, traditional helpers, and those who wish to share traditional forms of helping with counsellors who make the invitation to incorporate Native methods (See Blue & Darou, 2005; Duran, 2006; McCormick, 1996). A very important aspect to these processes is the notion of interconnected between individuals and community and within and across the four aspects of the self (mental, physical, emotional, and spiritual). Yet the most important part of these practices is that they come from local tradition and protocols, and to understand that these will vary from locale to locale and sometimes even within a specific community.

As described previously, Duran (2006) writes that the Western paradigm of mental health is marked by beliefs in logical positivism, linear thinking, and individualism that promote illness instead of Indigenous wellness: “Western trained therapists are trained to think within a prescribed paradigm that targets pathology” p. 19. Instead, counsellor training programmes could employ a pedagogy that targets mental health as wellness, as articulated in the study. Students training to be counsellors should also learn to enhance the cultural sensitivity of their own personal style of helping, as suggested by the participants who felt that the support of non-Native communities is necessary. Native and non-Native students training to become counsellors could begin this process by acknowledging, exploring, and clarifying their own values, worldviews, and beliefs related to their own culture and that of those who are different to them (Arthur & Collins, 2005). How could this be done in concrete terms in a learning environment?

- Through cultural self awareness exercises (see Arthur & Collins, 2005; Johannes & Erwin, 2004).
- Journaling exercises.
- Interacting with others from own culture and other cultures (individual and group field trips).
- Actively seeking knowledge and learning about diverse cultures (endless possibilities).
- Introduction of an Indigenous paradigm of mental health and healing as articulated in the results of this dissertation, including illustrations and practices as cited above.

Concluding and Moving Forward

In a movement to emphasize a sense of finality to this personal narrative, I suggest that this research has reflected not only the mental health as understood through Native counsellors’ stories, but my own evolving identity as an Indigenous scholar. The conceptual framework informed the direction of the research in terms of the research question, methodological approach, research sites, and even participant selection. Yet it also reflects both who I am as cultural being and as a philosophical agent. These frameworks allow others who read about this research to understand my perspective as researcher by giving insight to my Indigenous values and philosophies as they underpin this project. Thus in this way, I am inviting the academy into understanding and being accepted by the Indigenous paradigm, instead of the Indigenous worldview seeking validation from the Western experts. Future research, including mental health research could explore this relationship in this way by asking both native and non-native scholars what their experiences and understandings of knowledge is. Future research could also explore positions of researchers both within the academy and in non-academic contexts relative to cultural perspectives on health, education, and knowledge. The possibilities are truly endless for the next steps. This embarkment is a long and slow road, measured by degrees and not by accomplishments. However, it is also an exciting journey for me to both learn more about our rich and varied Indigenous Canadian cultures and how to successfully negotiate a new relationship with Western institutions of power and knowledge that could possibly be based on equity, trust, and a thirst for new (and ancient) knowledge.

References

Arthur, S. & Collins, S. (2005). Introduction to culture-infused counselling. In N. Arthur and S. Collins Eds., *Culture-Infused Counselling: Celebrating the Canadian Mosaic*, (pp. 10-15). Calgary, AB: Counseling Concepts.

Barton, S.S. (2004). Narrative inquiry: Locating Aboriginal

epistemology in a relational methodology. *Journal of Advanced Nursing*, 45 (5), 519-526.

BC ACADRE. (2005). Application for funding. Retrieved January 15, 2009 from http://www.mpcbc.bc.ca/files/CallforApplications_Guidelines_2005.doc.

Blue, A. W. & Darou, W. (2005). Counseling First Nations peoples. In N. Arthur and S. Collins Eds., *Culture-Infused Counselling: Celebrating the Canadian Mosaic*, pp. 303-330. Calgary, AB: Counseling Concepts.

Brant, B. (1990). Native ethics and rules of behaviour. *Canadian Journal of Psychiatry*, 35, 534-539.

British Columbia Statistics (2003). *Statistical profiles of Aboriginal peoples*. Retrieved 01 May, 2007 from http://www.bcstats.gov.bc.ca/data/cen01/abor/ap_main.asp.

Corsiglia, J. & Snively, G. (1997). Knowing home: NisGa'a traditional knowledge and wisdom improve environmental decision making. *Alternative Journal*, 23 (3), 22-27.

Creswell, J. W. (2005). Educational research: Planning, conducting and evaluating qualitative and quantitative research. Upper Saddle River, NJ: Patience Hall. *Counseling*, 21, 33-41.

Denzin, N. & Lincoln, Y. (2000). *Handbook of Qualitative Research* (2nd edition). Thousand Oaks: Sage Publications.

Duran, E. (2006). *Healing the Soul Wound*. New York: Teachers College, Columbia University.

Erasmus, P. & Ensign, G. (1998). *A Practical Framework for Liaison Work in Native Communities*. Wetaskiwin, AB: Taylor Printing.

Escobar, A. (1998). Whose knowledge, whose nature? Biodiversity, conservation, and the political ecology of social movements. *Journal of Political Ecology*, 5, 54-82.

Gadamer, H. G. (1994). *Truth and method* (J. Weinsheimer & D. G. Marshall, Trans.) (2nd ed.). New York: Seabury Press.

Gadgil, M., Berkes, F., & Folke, C. (1993). Indigenous knowledge for biodiversity conservation. *Ambio*, 22, 2/3, 75-91.

Hudson, P. & Taylor-Henley, S. (2001). Beyond the rhetoric: Implementing culturally appropriate research projects in First Nations communities. *American Indian Culture and Research Journal*, 25 (2), 93-105.

Johannes, C. K. & Erwin, P.G. (2004). Developing multicultural competence: Perspectives on theory and practice. *Counselling Psychology Quarterly*, 17, 3, 329-338.

Kenny, C. (2000). A Sense of Place: Aboriginal Research as Ritual Practice. *Voice of the Drum: Indigenous Education and Culture* (pp.139-150). Brandon, MB: Kingfisher Publications.

Lee, C.C. (Ed.) (1995). *Counselling for Diversity*. Needham Heights, MA: Allyn and Bacon.

Leninger, M. M. (1985) Care facilitation and resistance factors in the culture of nursing. *Topics of Clinical Nursing*, 8 (2), 1-12.

Lincoln, Y. S. & Guba, E. (1985). *Naturalistic Inquiry*. Thousand Oaks: Sage Publications.

Mattingly, C. & Lawlor, W. (2000). Learning from stories: Narrative interviewing in cross-cultural research. *Scandinavian Journal of Occupational Therapy*, 7, 4-14.

McCormick, R. D. (1996). Culturally appropriate means and ends of counselling as described by the First Nations of British Columbia. *International Journal fore the Advancement of Counseling*, 18, 163-172.

McCormick, R. (1997). Healing through interdependence: The role of connecting in First Nations healing practices. *Canadian Journal of Counselling*, 31 (3), 172-184.

Medicine-Eagle, B. (1989). The circle of healing. In N. R. Carlson, B. Shields, & J. Brugh (Eds.), *Healers on Healing* (pp. 58-62). New York: J.P Tarcher/ Putnam.

Mussell, W. J., Nichols, W. M., & Adler, M. T. (1993). *Meaning Making of Mental Health Challenges in First Nations: A Freirean Perspective* (2nd Edition). Chilliwack, BC: Sal'i'shan Institute Society.

Peavy, V. (1998). *Socio-Dynamic Counselling: A Constructivist Perspective*. Victoria, BC: Trafford Publishing.

Piquemal, N. (2001). Free and informed consent in research involving Native American communities. *American Indian Culture and Research Journal*, 25 (1), 65-79.

Schwandt, T. A. (1997). *Qualitative Inquiry: A Dictionary of Terms*. Thousand Oaks: Sage Publications.

Silverman, D. (2001). *Interpreting Qualitative Data: Methods for Analyzing Talk, Text and Interaction*. Thousand Oaks, CA: Sage Publications.

Smith, L. T. (1999). *Decolonizing Methodologies: Research and Indigenous Peoples*. New York: Zed Books.

Statistics Canada (2003). Retrieved on May 01, 2005 from http://www12.statcan.ca/english/census01.

Taylor, S. J. & Bogdan, R. (1984). *Introduction to Qualitative Research Methods: The Search for Meanings*. Toronto: John Wiley and Sons.

Tesch, R. (1990). *Qualitative Research: Analysis Types and Software Tools*. New York: Falmer.

Thunderbird, S. (2005). *Medicine Wheel Teachings*. Retrieved June 15, 2005 from http://www.shannonthunderbird.com/medicine_wheel_teachings.htm.

Wavey, R. (1993) International workshop on indigenous knowledge and community based resource management: keynote address. In: Inglis, J. (Ed.), *Traditional ecological knowledge: concept and cases*. International Development Research council and Canadian Museum of Nature, International Program on TEK, Ottawa, 11-16.

Wenzel, E. (1997). Environment, development and health. Ideological metaphors of post-traditional societies? *Health Education Research*, 12 (4), 403-418

Whitmore, E. (1994). To tell the truth: Working with oppressed groups in participatory approaches to inquiry. In P. Reason (Ed.), *Participation in Human Inquiry: Research with People* (pp 83-98). London: Sage Publications.

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First Peoples Child & Family Review
A Journal on Innovation and Best Practices in Aboriginal Child Welfare Administration, Research, Policy & Practice

Volume 4, Number 1, 2009, pp. 66-79

Metaphorical Reflections on the Colonial Circus of the Drunken Indian and the Kidney Machine

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Abstract

This paper represents the need for First Nations community workers to share their narratives of experience and wisdom for academic review. A growing number of mature Indigenous social service workers are returning to Canada's learning centers where they are articulating observations and insights to Indigenous experience in colonial Canada. It is imperative that post-colonial academic literature include these contributions. True reconciliation between Canada and First Peoples is only possible if those stories of resilience are reflected back from the experience of historic trauma and unresolved intergenerational suffering.

> *"There are numerous oral stories which tell of what it means, what it feels like, to be present while your history is erased before your eyes, dismissed as irrelevant, ignored or rendered as the lunatic ravings of drunken old people. The negation of Indigenous views of history was a critical part of asserting colonial ideology, partly because such views were regarded as clearly 'primitive' and 'incorrect' and mostly because they challenged and resisted the mission of colonization" (Smith, 1999:19).*

Introduction

The field of Cultural Psychology has been a major influence on the 25 years of community work I have done in First Nations communities both urban and on reserve, and most recently on remote fly-reserves in northern Ontario. The writings of Clifford Geertz, Jerome Bruner, John Berry and Eduardo Duran have been helpful in finding mediums from which to forge the tales of change, continuity and growth for the First Peoples of Canada. Through their work I was introduced and became very interested in cultural safety and healing from trauma. Their writings provided me with an opportunity to step back, frame, and get a clear sense of the strength and resilience of Canada's First Peoples in the face of what has come to be known as cultural genocide. They taught me that there is a way to recover the deeper strengths of a people verses an unrelenting expression and fixation on pathology. I use the terms Indigenous peoples, First Nations people or First Peoples throughout this paper because the term Aboriginal is a political definition created by agents of oppression that have equally confounded the socio-historical realities of an entire Indigenous population. The word Indian is used to remind myself of what it feels like to have your identity reduced to a carnival sideshow oddity or circus freak. Modern sensitivities still allow, push and tolerate iconic mascots and other images that devalue the term "Indians" as a designator for a diverse and complex range of cultures, languages and life experiences.

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Clifford Geertz (2000), in his collection of essays titled Available Light reflected on the importance of promoting discourse theory in cultural psychology. How stories are expressed draws on the cumulative knowledge of language, art, literature, history, law, philosophy and what he calls an "inconstant science", anthropology. He writes;

> *"It has been the convention of most schools to treat the art of narrative-song, drama, fiction, theater whatever-as more "decoration" than necessity, as something with which to grace leisure, sometimes even as something morally exemplary. Despite that, we frame the accounts of our cultural origins and our most cherished*

Acknowledgement

The author is eternally grateful to Indigenous scholars such as Dr. Cynthia Wesley-Esquimaux, Dr. Suzanne Stewart, Dr. John-Paul Restoule, Lee Maracle (Honorary PhD long overdue) and Marlyn Bennett (PhD in progress) for providing a culturally safe space to write and reflect on sometimes lonely journeys of recovery. Indigenous thinkers and scholars play vital roles as path-finders and mentors to navigating the rigors of academia. Academic spaces remain foreign, perplexing and not necessarily ready for some of the stories coming in from "Indian country." The metaphoric carnival or circus of colonization that is offered in this paper will hopefully provide a framework for contextualizing long-standing misunderstood and mislabeled 'pathologies' such as uncivilized drunken Indians. Notions that confound and defy Indigenous cultural rationalizations but continue to inform a colonizer's view of "who" Aboriginal peoples apparently are.

> *beliefs in story form, and it is not just the "content" of these stories that grip us, but their narrative artifice. Our immediate experience, what happened, yesterday or the day before is framed in the same storied way. Even more striking, we represent our lives (to ourselves as well as to others) in the form of narrative. It is not surprising that psychoanalysts now recognize that personhood implicates narrative "neurosis" being a reflection of either an insufficient, incomplete, or inappropriate story about oneself. Recall that Peter Pan asks Wendy to return to Never Never Land with him, he gives as his reason that she could teach the Lost Boys there how to tell stories. If they knew how to tell them, the Lost Boys might be able to grow up. (p.193)"*

Therefore, perhaps the biggest challenge and burden for First Nations Peoples and their healers is to restore story-telling and promote the sharing of stories of cultural genocide and resilience in the realm of socio-historic victimization (Duran, 1995). This paper is a narrative collage made from fragments of experiences and observations of an Indigenous man raised on a travelling carnival, or the outdoor amusement industry, today a more politically correct euphemism. One day I hope to write a book titled "Running the Alibi: Observations and Recollections of a Half Breed, Carny Bum" to weave together narratives that draw parallels between the carnival or circus life and Canada's absurd domination of First Nations. A thirty year social work, mental health, addictions counselor, land claim researcher and program design career in urban and remote First Nations community's offers useful insights to the never ending stories or "jackpots" told by lost boys. Running the alibi is the 'wise guy' way of gaining advantage over "marks", a carnival's apprehensive customers. Creative, confusing and colorful language manipulations hide predatory intentions and hungry realities. This paper is wrapped around metaphoric frameworks that mask gangster conduct which victimizes vulnerable folks. The parallels between carnival victims and Native people rest in the historic narrative of alcohol abuse and the unresolved historic trauma that continues to mark Indigenous people for perverse vulnerability. Colonization fits this distortion or alibi for greed because it shelters worst intentions and shields bureaucratic bandits from accusations of criminality and as perpetrators of chaos, including genocide, of Indigenous peoples.

Raphael Lemkin, a Polish Jew, led the development of a universal definition for the word "genocide" and spearheaded the passage of the United Nations first human rights treaty. Samantha Power (2000), in her book, A Problem from Hell, America and the Age of Genocide, tells the story of the fifteen year effort by Lemkin to make human rights an integral part of the United Nations. She also recounts the efforts of America and Britain to weaken Lemkin's work. In addition, Canada and Russia in the early years of the 21st century remain obstacles in a twenty year project at the United Nations to entrench human rights for Indigenous people around the world. Lemkin often used what he called "a constant prodding" to forever prevent another Hitler by noting that the "legislators imagination must be superior to the criminal" (Power, 2002:57). The General Assembly of the United Nations settled on December 9, 1948 on a definition of genocide as;

> *Any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial, or religious group, as such: killing members of the group; causing serious bodily or mental harm to members of the group; deliberately inflicting on the group conditions of life calculated to bring about it physical destruction in whole or in part; imposing measures intended to prevent births within the group; forcibly transferring children of the group to another group (Power, 2002:57).*

The history of colonization must begin by fully integrating the stories of genocidal experiences from the past seven generations in order to properly understand and fully comprehend First Peoples experience on this continent. First Peoples scholars are reviewing the anger and unresolved grief that is closely associated with sustained intergenerational trauma in order to make sense of the outcome of multiple losses and the subsequent marginalization of an entire people (Yellowhorse-Braveheart, 2004, Wesley-Esquimaux, 2004). This has been necessary to facilitate the re-civilization of Turtle Island (North America) and the enlivening of an almost completely silenced world-view. For the past fifty years,

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the majority of First Peoples healers' time has been focused on reviving victims of trauma from what we now recognize as an historical, cultural and spiritual genocide.

Having worked in areas of mental health, child welfare, justice, violence, addictions and youth with Fetal Alcohol Spectrum Disorder (FASD), I have long wondered how we can create healing environments where one is safe to tell their stories and organize their experience in the face of long standing trauma. The richness of generations of stories that once maintained social cohesion have long been devastated and replaced by a state of cultural shock. This shock follows unrelenting trauma from warfare, dispossession, poverty, disease, oppression and forced assimilation. Healing in First Peoples communities will take a massive transformation from "victimization" to "survivorship" to "victorization" (Wesley-Esquimaux, 2007) and the guiding of individuals through traumas that cannot be solely represented as individual fault. First Peoples need to acquire a comprehensive understanding that they did not deserve to be hurt and that telling their story will not lead to their being regarded as crazy. Equally powerful for First Peoples healing will be a realization that the historical upheavals and injustices that led to internalized self-hatred, and ultimately became interwoven in many generations of First Peoples families, was an almost exclusively external onslaught (Duran, 2006). Although, initially, cultural imperatives across First Nations did not promote active resistance to external social/political upheavals, because guests were welcomed, nor was it seen as necessary to fight to maintain rights in the face of "others" with more power, because it was a given by Indigenous peoples that rights were sacred. Faith in Treaties premised on reciprocity by Indigenous peoples, turned into alibis for greed for colonial powers. Land purchases came to represent conquest and domination. Today's generation of Indigenous scholars and healers bring unique perspectives to the reconciliation of historic trauma from Residential Schools, the 60's Scoop, and the continuing impacts of colonial institutions such as Corrections Canada jails. The justice system sustains what can be referred to as Canada's largest reserve, which contributes, as well as masks, an increasingly frightening legacy of problem drinking patterns, health and social issues, and growing unresolved mental health complications of those atrocities. Is homelessness in our homelands part of our 'homelandlessness' and a measure of the loss of family and community connection? Has the loss of positive Indigenous identities relegated First Peoples to sad representatives of museum-based cultures only to be paraded at opening ceremonies of Olympics or iconic images on banknotes? The broad spectrum between the drunken Indian and the noble savage remains unfathomable, especially for Indigenous children, who remain our most powerless and helpless victims of cultural, social and spiritual upheaval.

The tragic loss of two babies on the Yellow Quill Reserve (2009) in Saskatchewan last winter added to the roster of stories that painfully remind us of the kind of all too frequently occurring events which cause community helpers to despair. A drunken Indian dropped two toddlers in -50c without any proper protective clothing or shelter and their lifeless remains were found too many hours later, lost to traumatic degradation. The painful loss and suffering of innocent children continues to be a real and unrelenting tragedy for far too many First Peoples and their communities. Indigenous scholars must intercede in instances where holistic community wellness issues beg to be loudly addressed rather than allowed to fall into a silence that prevents scrutiny of our collective natural responsibilities to future generations. This scrutiny is paramount as restorative justice is being contemplated at Yellow Quill. This move challenges all First Peoples to break the silence that allows hurt people to hurt other people, especially when they are our children. Why does the silence in our communities only get broken through the lament of mothers, grandmothers, sisters, brothers and yes fathers too, when we face the loss of innocent lives to preventable atrocities like suicide and murder? As a parent, my feelings of despair lay in knowing that when we neglect, fail to protect, and ultimately abandon our children to the cruelest aspects of life, we are in fact, complicit in killing them. I recently returned from community work in northwestern Ontario as a community mental health worker where I dealt with every possible social issue that can bubble forth from a failure to provide basic safety to all young people, and I feel very much a personal failure for not being able the make a discernable difference in such extreme circumstances. Are we as a people willing to address the need to create a re-parenting process for our children in order to restore the very basic human concepts of what families are supposed to offer? We as First Peoples in Canada are facing an uncertain future because we are forgetting the needs of future generations in too many places. Our thoughtlessness is evident when drunkenness replaces the protection of our most precious gift from Creation.

In the north, and in southern Ontario, I ran violence prevention workshops called the "Children are Watching" in an effort to teach our people how to re-establish safe environments. Successive generations of children have become physically, socially emotionally and spiritually lost during their living experiences, and many have died, sometimes because of adults being unable to assume their traditional roles of preparing our youth for humane and positive citizenship. After reading about the Yellow Quill tragedy I see a need to prepare new workshops on "Who is Watching Our Children?" This "challenge to protect our children" must be spoken out loud, the silence broken, as a part of our own struggle against historic impacts. We must

admit to each other that our survival as a healthy and strong people requires that we do whatever we can to protect the lives of our children, all of them, everywhere. Wars are fought over less.

Working with FASD youth in Hamilton, Ontario involved teaching youth to know one story for each of the Seven Grandfather Teachings: Wisdom, Love, Respect, Honesty, Bravery, Humility and Truth. These values were given as guides to wise problem solving and decision-making (Koptie, 2004). These teachings, given from a strengths model perspective, allowed us to encourage FASD young people to avoid impulsive behaviors that were problematic and dangerous. The need for safe external oversight or an external brain support (therapist, counselor, house matron) is not fully appreciated in environments unprepared for the massive special needs of neurologically damaged youth. This is possibly the most important narrative that we have failed to share and in the end the suffering of young people becomes inexcusable when we consider the huge revenues from the marketing and sale of the teratogen, alcohol. Mate (2007) describes Bruce Alexander's concept that any susceptible organism under stress with access to a drug with addictive potential is vulnerable to addiction in their struggle to relieve physical, psychological, spiritual and social environmental pain. This is not a race issue as all races are impacted by alcohol abuse.

The narrative missing from the Yellow Quill experience is a long overdue and honest dialogue on the reality of FASD/ARND. Fetal Alcohol Spectrum Disorder and Alcohol Related Neurological Disorders (FASD/ARND) must be the Creator's most poignant challenge to First Nations people to re-examine and re-introduce responsible sobriety right across Canada. The loss of successive generations of hope on the ground in our First Nation's suggests a "massive drunken metaphor of excess" which causes me to fear a continuing and unrelenting destruction in specific segments of our societies, our youth. My research goals encompass the following questions; is it possible to reverse the loss of hope for many families that FASD represents? Can we reverse our collective failure to act to preserve and advance a healthy childhood and the coming of age of our youth? Will our children, subjected to teratogens (agents of birth defects) in the womb, be able to assume a role in the restoration of home and community that we seek in the healing process? Are youth repeating pathological cycles of self-destructive and self-defeating behaviors because of gestational brain damage? What about the young father in Yellow Quill, has anybody asked the obvious questions? Where will the carnival be set-up next? Will the continued abusive consumption of alcohol mean a continuity of decline rather than a return towards our natural sovereignty? (Mohawk Girls, 2005). These questions have global implications when the precious gifts the Creator has offered are being mistreated and neglected. There are many perspectives that First Peoples scholars may want to review in order to articulate and orientate our experience and build a way forward in the face of tragic "on the ground crises" that paralyze many First Nations communities. They also confirm many of the traps of "Systemantics" that John Gall (1975) and Alfred Korzybski (1933) claim lead to never ending patterns of catastrophe.

Making sense out of nonsense is the most important service provided by gifted Native helpers. Our marvelous humor suggests a legacy of resilience in enduring trials and tribulations that accentuates the ironies of our circumstance. Those immersed in bringing health alternatives to First Peoples rarely get the recognition they deserve or any real understanding from Euro-centric experts. This paradox has led me back to the words of John Gall (1975) whose field of interest, Systemantics, the study of organizational behavior, became the main focus of my studies at University of Windsor in the 1970's. Gall sought to explain "how systems work and especially how they fail," and he demonstrated how a lot of things do not work well and in fact never did. As a returning graduate student, I want to return to some of these ideas so that I can use those theories to reflect on 30 trying years of mostly failure to shift social work "best practices" to "wise practices" (CAAN, 2004) on behalf of First Peoples. This has been daunted by a dominant social system more inclined to maintain racial supremacy, than restore human dignity. The big lie, that civilization is good for us (Trudell, 2004), is held up, but what really happens is that instead, a systemic attack on First Peoples is undertaken, the most recent that by Widdowson and Howard (2009), and this is very much representative of the failure John Gall wanted to present as silly collective ignorance;

> *Charles Darwin made it a rule to write down immediately any observation or argument that seemed to run counter to his theories. He had noticed that we humans tend to forget inconvenient facts, and if special notice is not taken of them, they simply fade out of awareness. (Gall, 1986:xx)*

Inconvenient facts or truths are not limited to the language of denial that Al Gore (2006) attributes to climate change. He cites political, economical, and social inaction as significant contributors. Gall (1986) suggests that there are cascades of failures or sequential events by which a system fails, each following a failure to contain the initial mistake. The Indian Act surely represents systemic institutional approaches to assimilate or integrate First Peoples into the dominant culture, whatever that integration may represent within the Canadian consciousness. He claims an awkward metaphor can be used to distinguish a system that can be turned on but cannot be turned off. He would have termed such systemic entities as the Indian Act, a Frankensteinian Monster.

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Gall's ideas reflect a profound logic which describes the paradox of invented bureaucracies such Indian and Northern Affairs Canada (INAC) where those administering this system become so narrow and specialized that they lose connection with an outside reality. Insular directives from deep within this hierarchal structure almost assure that the system itself cannot do what it says it is doing. Real world experience is excluded from what is reported up and down the system; resulting in the big lie (Trudell 2004). This is how it becomes a Frankensteinian Monster that ultimately disintegrates into "systemantic" chaos, with the inherently tragic consequences that ultimately follow. First Peoples today live within what Lee Maracle (2009) has termed "plunder zones." The failure of removal and assimilation outlined by Indian Act policy has justified unmitigated access to Indian lands and resources. The fact is we are enmeshed in a Victorian era strategy in the 21st century for governing the territory now called Canada. The Dominion of Canada is still dependent on concepts like reserves and Indian status, but this dependency can no longer hide race-based rationalizations for colonization and Euro-centric white supremacy.

Gall's work can be utilized to move beyond futile debates on making a monster system work. His work comes from his study of Alfred Korzybski (1933) and his work in general semantics. The work of these scholars furthers my desire to reframe our collective experience as First Peoples and speaks to the need to articulate that historic experience in our own words and stories. Disharmony is human relationships is due to limited thinking and misconceived abstractions. Albert Ellis (1975) the father of rational emotive and cognitive behavioral healing gives an appropriate example that could address other crazy misconceptions, lazy Indians and Indian time, and can even be regarded as a good rendition of running the alibi:

> *In his famous book Science and Sanity, Korzybski lambastes the "'is' of identity," claiming that when we state "A is lazy" this means something quite different from the descriptive statement "A does not get up in the morning" or "A refuses to get up in the morning." For the statement "A is lazy" can mean many things and may represent many different orders of abstraction. It may mean for example, "A sometimes does not get up in the morning," "A rarely gets up in the morning," "A gets up early in the morning but procrastinates about taking a shower," "A deliberately gets up late in the morning," "A tries hard to get up early in the morning but against his will falls asleep again," and so on. The statement "A is lazy" seems to mean A always, under all conditions, does things late or never. But does it? Usually, of course, it doesn't. But we continually employ such omnibus-sounding statements. Wrongly! (pg. vii)*

Liberation from domination according to Lee Maracle (2009) will come from implementing creative plans against ridiculous abstractions that maintain oppression, racism, sexism and colonization developed from within our traditional wisdom and knowledge that are carried in our stories of survival and renewal.

Korzybski's work, Science and Sanity (1933), contains his famous axiom "the map is not the territory". This axiom was his challenge to those who misuse language and communication and attach foolish meaning and descriptions to ideologies requiring abstract levels of thought. That we accept normative representations as factual has devastating consequences for our well being as people. The drunken Indian is a sad stereotype that is widely accepted as the representation and perceived identity for a whole race. It is an icon locked in the collective consciousness of the dominant culture that misrepresents the real evils of the existential space between the present and historical experience of all humanity. This creation of inferiority through social pathology maintains a language of the "other or outsider" that is used to legitimize racial supremacy. How can we feel sorry for drunken people whose existence is dependent on the evils of alcohol? One of the 20th century leaders of civil rights, who fought for transformative change that allows for President Barak Obama, the Reverend Martin Luther King Jr. (1963) referred to these evils in his own writing in regards to America:

> *Our nation was born in genocide when it embraced the doctrine that the original American, the Indian, was an inferior race. Even before there were large numbers of Negroes on our shores, the scar of racial hatred had already disfigured colonial society. From the sixteenth century forward, blood flowed in battles over racial supremacy. We are perhaps the only nation which tried as a matter of national policy to wipe out it indigenous population. Moreover, we elevated that tragic experience into a noble crusade. Indeed, even today we have not permitted ourselves to reject or to feel remorse for this shameful episode. Our literature, our films, our drama, our drama, our folklore all exalt it. (King, 1963: 110)*

That the representation of "Indians" does not reflect the First Peoples of North America represents a crucial paradigm shift even for First Peoples who are fighting to recover and restore a place in their traditional territories and within the human domain. Freedom from persecution, oppression, and marginalization requires redefining ourselves and taking our rightful place on lands where our spiritual connection is embedded. Redefining relationship based languages and ways of existing, not yet recorded in the consciousness settler populations, will restore that connection. Settlers cannot know the map or territory when they seek only to plunder riches, hence the plunder zone,

with a greed that requires savage destruction of all levels of creation, including human. Our retelling of the story of Turtle Island for the coming seven generations is all our ancestors expect from us. The need to heal the scars of trauma from systematic alienation generated by the Indian Act is a battle of attrition for control of Canada. It is a battle that may or may not end our existence as a race:

> *Our Peoples have been denied both our dignity and humanity…Our Peoples in our relationships with the lands, waters and resources from which all life flows. The spirit of the land infuses our identity and life as Peoples. The distinctness of our lands and waters gave rise to the diversity of languages, cultures and laws of our Indigenous Nations. We are who we are as Indigenous Peoples because of our communities' adherence to our shared past and collective future. (Walkem and Bruce, 2003:347)*

Ignorance and arrogance of societies that hold up such myths as empty lands or terra nullis as justification for colonization without full consciousness of the impact on the future legacies of their own peoples, let along the displaced, was what Korzybski sought to articulate. There were costs to all humanity, the settled territorial inhabitants in particular, but also to the mental wellness of those who have maintained delusionary rationales to cover their colossal errors against humanity.

The concept of "Indian" is not associated with ethnicity but has historically been a stage set in a social evolutionary ladder (Duran, 1995). It derived in part from the myth of the Wild Man and is directly oppositional to the equally ethnocentric concept of the Noble Savage. This limited identity was promoted by the first generation of anthropologists who were in effect socio/cultural missionaries competing for the privilege of anthropomorphizing those Savages. In the background was the relentless battle to occupy lands of a vast wilderness, thereby setting off a situation summarized by Benjamin Franklin in the 18th century by the following quote, "indeed if it be the design of Providence to extirpate these savages in order to make room for the cultivators of the earth, it seems not improbable that rum may be the appointed means. It has already annihilated all the tribes who formally inhabited the seacoast" (Duran 1995:125). That alcohol became part of the economy and a means of extracting concessions in dealing between two groups with conflicting values and intentions requires a great deal of examination especially in formulating healing strategies in First Nations communities today (Duran, 1995). An elder once describe how 100% of First Nations people are hurt by the misuse of alcohol. Eduardo Duran's book, Native American Postcolonial Psychology contains an important and significant review of the drunken Indian as a Eurocentric concept that fails to define the meaning of alcohol to First Nations people from a cultural, social, economic, political and historic point of view. He asks us to consider alcohol as having a spirit, which many of his First People clients describe. "Why do they call it a spirit"? He asks then responds,

> *When the patient is in search of spirit to replace the spiritual and existential emptiness caused by the soul wound, ego (the aspect of the personality in which the personal identity and experience is accessible) projects into the spirit of alcohol. The spirit of alcohol then is introjected by ego and consumed by the person in its physical form…In essence; the person is replacing spirit with alcohol spirit in an attempt to fill the void created by historic trauma (Duran, 2006:65).*

It creates a negative identity without helping a people to understand the illness, disease and social pathology of alcoholism. C.L. Higham (2000) provides a useful telling of the mutual dependency social scientists and government developed in civilizing Indians in North America. The most interesting story for Canada in this outline is the role of the Hudson's Bay Company in preventing the massacres of America in Canada for the sake of trade. Alcohol was a currency of that trade and much of the work of missionaries did was to lessen the damage from reckless usage of alcohol in order to create a spirit of cooperation. Canadian conquest of the frontier was profoundly different than the American approach (Higham, 2000). The common experience for First Peoples was brutal dislocation and an inability to recover from relentless onslaughts of migrations through Indigenous homelands. This again requires more study by First Peoples scholars to create a more reflective discourse for the social policies that brought Treaties, the Canadian Indian Act, Residential Schools, the Sixties Scoop, and the marginalization of Corrections Canada. Teaching the next generation of First Peoples social workers healing skills will require an inclusive socio-historical perspective that traces rampant pathology to these sad legacies.

The role of healer in a traditional or clinical role involves being a guide to piecing together shattered lives more resembling a scattered jigsaw puzzle. Through their influence I have gained training, professional role modeling, clinical experience and traditional teachings to help others reconfigure the pieces or stories of their experience. Traditional crafts and the practice of quilting can also create unique expressions that promote the sharing of stories and the transmission of core cultural values. There is a remarkable movie called the "How to Make an American Quilt (1995) by Jocelyn Moorhouse, starring Winona Ryder, Anne Bancroft and Maya Angelou. It tells stories within the framework of creating a quilt. The story does not present itself until all pieces are lovingly stitched together. The quilt is a metaphor for finding beauty in

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fragments or patches in cloth that comes together to create a lived story. In life these are the lessons of love, desire, betrayal, anger, heartbreak and forgiveness. This movie lets us follow a 26-year-old woman, Finn's (Winona Ryder), who is struggling with a life transition to that of an adult woman. Her access to the wisdom of older women in her life was for me a reminder of the horrific silence between First Peoples women and the failure to incorporate traditional values and life lessons in everyday living. In northwestern Ontario I initiated sewing groups for women to meet and share their stories with youth with a goal to creating healing quilts that would represent a lasting symbolism of their bonds. The ultimate goal was to restore the spirit of grass roots women to love, care, and share strengths in the face of an oppression that chokes the life spirit in most reserves. Culture like a quilt conveys an ethos or rubric that provides meaning, direction and coherence to its insiders. It is the collective utilization of natural and human resources to sustain our humanity. To that end it affects the way we feel, think and behave, (Berry et al. 1992).

First Nations author Lee Maracle teaches that trauma may best explored by artistic expressions such as poetry, theatre, painting, and story telling. The classic dimensions of isolation, hopelessness and victimization can be captured by words, (Amrani, 1993). A poem by Nila North Sun in Amrani (1993) highlights the contemporary First Peoples use of poetry as storytelling for expression of loss, anger, brutalization, alienation and prejudice:

shadow is
my cousin
shadow was
my cousin
hated herself
because
others hated her
whites hated her
Indians hated her
called shadow
apple Indian
whites saw only INDIAN
fat drunk greasy squaw
shadow didn't know
what she was
my cousin killed herself
nothing new
we have lots of cousins
both dead & alive
sometimes
both
with the same shadow (pg.15).

Writing and story telling can allow for the expression of fragments of memory and recollections and evoke emotional expression. It allows a direct recounting of events long buried for the sake of self-preservation and mental health. Story telling is a long practice in First Peoples life ways, and ceremony and spiritual practices encourage community members to understand outside experiences as part of life that can bring suffering as well as goodness. This resonates for community helpers who incorporate an anti-ignorance and anti-arrogance approach to social work, or work with an anti-oppressive orientation to create healing environments. The goal is to allow participants the dignity to share fragments of painful experience and shed the isolation suffering places on the victims of trauma. Life is cyclical and different levels of experience require the honoring of relationships in physical, emotional, social and spiritual realms. Giving thanks for all gifts from creation means embodying a humility that accepts love, caring and sharing as the true marks of good living. Hatred, jealousy and greed as regarded as selfish, destructive and harmful to living well, and these emotions can hurt future generations. Ceremonies and cultural rituals orient First Peoples to a strengths based worldview. Unfortunately, the ignorance and arrogance of settlers confused the cultural relevance of Native adaptation to Euro-centric concepts with settler notions of racism, classism, sexism and the spiritual disunity they used to marginalize others through imposed inferiority.

Memory sharing through story telling means careful attention must be paid to moving healing narratives into, through, and beyond painful recollections so they are not merely released, but also form a foundation for relinquishing (Bear Heart, 1996) the damaging impacts of physical, psychological and sexual trauma (my emphasis). The blending of preventive life lessons to end abusive behaviors can bring ownership of harmful lifestyles that sometimes have a multigenerational foothold in families and communities. For instance, modern healing ceremonies are being tested and blended with traditional modalities out of a growing understanding of what residential school experiences represent for survivors, and how it changed their cultural orientations. As Elder Fred Wheatley in known to have stated, "We have to live in the world in which we find ourselves." In practice an invitation to share knowledge out of a linguistic interpretation can be an entry point to healing and change. In residential school healing circles in remote northwestern Ontario reserves participants were encouraged to find the words in their Oji-Cree language to denote the evil of harm to children. This linguistic exercise generally offered an important shift from painful silence to seeking a framework for story telling and memory recovery. These healing sessions were conducted over several days and the transition from fear and shame to support and empathy was a rewarding experience for

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all participants, including the facilitator. Collectively they were able to find a language of shared experience, wisdom and courage.

As an organizer of such sessions, the greatest reward came from being a witness to movement toward the restoration of a sense of connection in family, community and even nation. Participants became aware that rather than being ashamed about the loss of collective language or cultural identity, because they each carried fragments of wisdom and traditional knowledge; they could prompt their healing as a group. Another group exercise was done to assist parents in approaching their children to express their hidden pain in perceived failures in parenting and to formulate new loving attachments. They needed to let go of their need for fierce control over the possible disclosure their own youthful exuberance and subsequent mistakes that had not been given voice. They were asked to place their hands on their heads and state "I did not know" then place their hands on their hearts and exclaim, "I am so sorry". These acts of personal and psychological liberation have become a part of a truth and reconciliation process that this author continuously strives to facilitate.

Geertz (2000) states that, "psychology's next generation will help resolve these deep on-going issues by highlighting narrative as a primary way of knowing our reality" (p. 193). He directs us to the work of Jerome Bruner, who he calls one of the leaders of the Cognitive Revolution. Bruner has noted that it is the analyst who facilitates the constructional process of the telling of self-stories. The self derives from individual meanings and cultural participation. "The human mind and lives are reflections of culture and history" as well as biology (Geertz 2000, p.198). For Bruner "narratives" show how experience is organized and becomes sequential, following sets of events, mental states, and other responses. Therapy often entails the huge task of safely taking someone through life sequences, which have been interrupted by intrusive painful memories. Jerome Bruner's writings on cultural psychology offer endorsement for First Nations social change activists using cultural narratives. These stories offer a reality testing revision of conventional or colonial based understandings of what is wrong in our communities. Bruner calls culture "the way of life and thought that we construct, negotiate, institutionalize, and finally (after it is all settled) end up calling 'reality' to comfort ourselves" (Geertz 2000, p. 192). A story or narrative that Marlene Brant-Castellano (1987) uses to frame cultural teachings represents another important way of knowing:

> *If you're out on the lake in a canoe and a sudden storm blows up and your canoe tips over, you will have a stress reaction. You will have a surge of energy and you can do any of three things. You can give up and sink like a stone. You can get angry and thrash about, at which point you will get exhausted and drown or you can channel your energy, you can hang onto your canoe and wait for the storm to pass and then deliberately upright it and get back in. But how do you know not to panic? How do you know that you don't fight the storm and how do you know to get your canoe upright? How does any body learn these things for survival? What, I believe very firmly, what we as Native people need to do is to actively search out those teachings which instruct us in how to wait out the storm, if that's the survival way to go. The technology of how to handle a canoe and read the weather so we don't get into a storm in the first place and how to discipline ourselves in order that we choose the creative solution and not the one that destroys those around us (p.87).*

This is a profound message that could be a real key turner in workshops for violent men, for allies in stopping FASD, and to create prevention strategies for suicide and addictions. The loss of teachers, elders, positive youthful role models and mentors of all ages for First Peoples youth leads to our losing them to gangs, violence, incarceration and substance abuse. Mate (2007) in writing about addictions states;

> *Neglect and abuse during early life may cause bonding systems to develop abnormally and compromise capacity for rewarding interpersonal relationships and commitment to social and cultural values later in life. Other means of stimulating reward pathways in the brain, such as drugs, sex, aggression, and intimidating others, could become relatively more attractive and less constrained by concern about violating trusting relationships. The ability to modify behavior based on negative experiences may be impaired (p.197).*

We must engage in family and community reality checks that offer insights beyond basic survival to understanding how our children are leaving their family and community of origin. The decline in our youth and family well-being shows its painful face in incredible loses to suicide and early death through recklessness, self-destructive and self-defeating behaviors. In many instances, communities in the north in particular, have little support to recover and restore hope. Together with a failure to provide young people with strength-based cultural wisdom and preparation for assuming prominent roles, are the obvious markers of dis-ease and early death in our nations (Wesley-Esquimaux, 2009). We need to create a narrative path focused seven generations ahead to mitigate the historical damage of our 19th and 20th century experience. In the 21st century we face the very prospect that issues like suicide, sexual violence and increasing numbers of FASD/ARND incarcerated youth will continue to impair our journey forward. We need to look everywhere

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for indicators of extinction, especially in our Indigenous homelands in remote Canada. There we are impacted by mining interests, forestry interests, and a chronic lack of societal care.

If we fail to move beyond what has manifested over time as a genocidal dependency on the colonizers and their cash, we will become footnotes of history like the Beotuks and Petun tribes that fell to the 17th and 18th century ravages of Turtle Island. For all of our peoples this was only one period of cultural devastation in the name of progress, we are fighting the same battle today in our northern hemispheres. We must teach our youth that they are the "last best hope" for all Indigenous people globally. The ultimate survival of Canada's First Peoples will be proof that genocide through the neglect of basic human rights to health care, economic sustainability, and educational facilities is not an acceptable tool for the continuing domination of mythical "empty lands" and the misrepresented peoples who live upon them. The myths around nationhood on Turtle Island are clearly up for debate and new alliances must be made possible to formulate a just and equitable society. The truth and reconciliation process still being contemplated but at this time problematic in design by Canada, though discomforting to its government and Churches will give young First Peoples real stories to organize their experience through and will hopefully provide an invitation to recover, relinquish historic trauma, and restore traditional life-ways.

Lee Maracle (2009) teaches that successive generations have been obstructed in their ability to help their children navigate and negotiate racism, classism, sexism and colonization in their "coming of age" life journey. She lectures on the failure of adults through their absence being unable to teach autonomy and adaptation skills for youth struggling to gain authority in their life path. Adults are to assist in clearing a path of mastery by moving strengthened minds and bodies towards good will and Biimaadiziwin for successful life paths. Maracle (2009) calls the lifespan ages 13 to 20 the "Days of Decision" where young people navigate and negotiate how 'all my relations' will play out in their own lives as guideposts to ecological reciprocity. Their sense of connection is a vital part of the resilience they need to pass through periods of uncertainty and confusion. Chaotic rhythms in their homes and alienation of their homelands lead to feelings of despair, helplessness, hopelessness and ultimately to an identity crisis that make living seem impossible. The excesses of violence, substance abuse and suicide must be examined from the context of the youth watching and deciding. We must also consider the implications of neurological damage from FASD that compound an increasingly urgent need to stop damages and instead maximize human potential within our growing youth population. By the age of 25 when society expects young people to be fully functioning and contributing to society, our youth remain in what elders call the Wandering Stage of life (Maracle, 2009). Instead of contributing, they follow a self-centered path of uncertainty, not knowing their place in the world, which in turn leads to selfishness, recklessness and carelessness.

Marlene Brant-Castellano's (1987) story-telling paradigm may offer clues to how these panic causing life storms can also create pathways of knowing and crucial growth opportunities, because the failure to formulate positive life-paths for young Native peoples will only continue to contribute to chaos and uncertainty. Not taking charge of these teaching opportunities threatens our cultural competence and cultural survival. Think of the narratives of possibilities that could be used to triumph over adversity, and that could direct and move youth beyond despair or mere survival.

The sharing of trauma experiences by residential school survivors who [as children] experienced and witnessed pain without being able to tell anyone is deeply moving. We have to honor the journey of self-discovery undertaken by victims longing for peace from their incomprehensible suffering. Their suffering in silence comes from not hearing resilience stories from adults in the healing ceremonies of their communities. Selekman (2002) addressed storytelling for First Peoples as a healing principle:

> *In the Native American culture, parents and elders tell stories as an effective way to teach younger generations valuable life lessons about caring for and respecting others, nature, and the Creator, as well as about gaining the courage and self-confidence to resolve life challenges. In fact, rather than being yelled at, grounded, or grounded, or receiving some form of physical discipline when they misbehave, young people are "disciplined" by being told stories that help them learn from their actions (p.106).*

Selekman (2002) speaks to self-harm and cutting behaviors in adolescents, one of the most serious risk behaviors in First Peoples communities, and youth. The cutting is reflective of the inner turmoil they keep to themselves and inflict onto their physical self. Alice Miller's (1990) book For Your Own Good: Hidden cruelty in child rearing and the roots of violence also contains an excellent review on how violence and cruel manipulation of children can create violent adults. There is also a valuable lesson for pedagogy in the legacy of untenable methods used in residential schools for "civilizing young savages". A story narrative, possibly also a science lesson, from the Fort Albany residential school is recounted in Joseph Boyden's (2005) novel Three Day Road:

The old Cree are heathen and anger God [the nun says] The Cree are a backwards people and God's displeasure is shown in that He makes your rivers run backwards, to the north instead of to the south like in the civilized world…

When you accept Him He will perform a great miracle. He will cause the rivers in this barren place to run in the right direction (p.52).

Bruner suggests our place in the world flows from meta-cognition or "how we think about our thinking" (Geertz 2000: 194). As described by Bruner, "history, culture, the body and the workings of the physical world, indeed fix the character of anyone's mental life, shape it, stabilize it, fill it with content but do so independently, concurrently, and differentially. He adds, "the way of life and thought that we construct, negotiate, institutionalize, and finally (after it is all settled) end up calling reality to comfort ourselves" (Geertz 2000: p. 192). I am drawn to the implications of this theory on my future work; especially my desire to be part of crucial preparations and closures for truth and reconciliation sharing circles that are an important feature of the Indian Residential Schools Compensation Package. The next 5 to 10 years will hopefully clarify many outstanding misunderstandings and misconceptions about the historical realities of Canada and the First Peoples who live 'here.'

The voicing of alternative perspectives for healing paradigms that respect Indigenous Knowledge may shine understanding on why mainstream mental health helping strategies have largely failed to assist in the restoration of the good life in our communities. The mislabeling of reactions to racism, classism, sexism, colonization and oppression as pathology have only entrenched stigma and stereotype. Interference in the natural evolution of the language and behavior of adaptation is rarely mentioned as an area of contention when considering how First Peoples have managed their own historical realities. Re-establishing community healing mechanisms, such as the sharing of narratives for exploring trauma from residential school memories, and naming the personal "dis-eases" generated from intensive human suffering and pain, will help to expose internalized negative beliefs. Self-reflection is critical to the restoration of Indigenous resilience. There are collective stories of multiple losses, beginning with the loss of connection to a family at birth, whether through FASD neurological damage or disproportionate foster care apprehensions, needing a complete reorientation of the sad cultural inheritance of seven prior generations. Much of this knowledge would be lost in a "systemantic" (Gall, 1975) attack on Indigenous community and has already undermined their core values of love, caring and sharing. It is necessary to remind all social workers that what constitutes "best practices" in the history of social regulation and the maintenance of the civilization we are asked to maintain and endorse as "civilized" is not necessarily coherent with First Peoples practices and worldviews. Does their alibis for remediation sustain state sponsored oppression, repression and dispossession?

Indigenous healers have always utilized "wise practices" (Thoms, 2007), which were based on harmony, balance and good will; they returned to and incorporated the inner spiritual and inner knowledge of place and spirit. The legacy of the unrelenting attacks and marginalization of traditional healers is ever present on the ground. Healers are faced with a continuity of suffering and despair from violence, sexually predatory behaviors, alcoholism and early death by self-destructive and self-defeating behaviors. Much of this behavior has become normalized to the point of creating deafening silence in the face of tragedies such as Yellow Quill, youth suicide or the loss of hope in our young in far too many places across this land. People are speaking out in various places, but are they being heard in the places that matter? The intense pain of earlier generations who were subjected to being deprived of a childhood still reverberates in First Nations communities in Canada, and is revisiting the world in areas where childhood is being destroyed by warfare, child prostitution, famine and disease. The restoration and recognition of "wise practices" offers the best hope for finding a way forward from the despair and hopelessness that permeates families and communities. We can no longer be dependent on a dominant culture interpretation of what it means to be successful and fully living First Peoples. Indigenous scholars must uncover the direct influences of Indigenous wisdom on the collective consciousness of the past seven generations, especially the 20th and 21st century of psychological and cultural impact.

In 1938 Abraham Maslow under the direction of Ruth Benedict conducted six weeks of fieldwork on the Blood reserve in Alberta. Maslow (1979) would affirm the value of Blackfoot worldview contributions to his psychology theories human behavior and human social organization, which began to evolve from lessons from the Blackfoot tribe. He witnessed the on the ground impacts of white racism which troubled him that confirmed destructive state policies that resulted in stolen lands, stolen children and collective marginalization. By 1967, only one generation away from his 1938 visit Maslow hears from A.D. Fisher, a graduate student he is supervising that addiction and violence were fast becoming the new social norms of the Blood community. Fisher (1984) calls for explanations of "how and why the outcome of "reservationization" turned out to be Indian underdevelopment in "the bountiful land of Alberta". There are Indigenous thinkers such as Ryan Heavy Head (2009) researching this little known story from Red Crow Community College.

Lee Maracle (2009) offers an interesting refection on Abraham Maslow's (1954) needs-based theory on human development and the motivating factors for a good life. She suggests for First Peoples, Maslow's hierarchy is an upside down pyramid. Maslow's idea of the triangle may have come from tipi teachings Maslow received in 1938 (Hanks,

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1950). This is an interesting example of a difference in worldviews that can shift psychological wellness concepts that Western thinkers promote as basic best practices to Indigenous Spiritual knowledge which is tied to creation and being of a good mind. If all life is spiritual first, then as Lee Maracle states, self-actualization is not the peak experiential calling for achieving a good life, it is the beginning. Traditionally, First Peoples viewed children as complete gifts from creation with their potential intact when they arrived, and that all members of a community simply prepared for communal membership. They are already filled; therefore, basic needs as Maslow describes them, are in fact, the last level of cultural competence for successful mastery of a good life. First Peoples know that kindness and sharing will naturally arise from achieving ones full potential. This inverted pyramid of a full spiritual life is little appreciated by so called "social helpers" who focus on what they perceive as poor living conditions. This visual becomes the tangible expression of poverty and pathology, rather than the result of a coercive removal plan named greed for the lands and resources of an entire population. Children are removed and First Peoples are punished to meet Maslow's basic needs for a selfish, indifferent and thoughtless dominant culture with no understanding of the spiritual connection to the future generations of Native peoples, or respect for the limits of their mother earth.

Compare this work to that of other modern ideas emulating from Albertan intellectuals especially from disciples of Tom Flanagan who question the validity of Indigenous knowledge and worldviews or claims to inherent human rights beyond what Canada is prepared to offer. He praises their questionable scholarly material that in context and content borders on racism and promotes rationalizations for continued white supremacy. Frances Widdowson and Albert Howard (2009) in their disturbing and misguided book "Disrobing the Aboriginal Industry: The Deception Behind Indigenous Cultural Preservation", raise valid issues on the growing industry of non-Aboriginal consultants profiting from First Nations misery, but denigrate Indigenous peoples throughout. Widdowson and Howard (2009) in a true social-Darwinism framework postulate, "to some extent the dislocation that [(a)boriginal] peoples are feeling is inevitable since it is difficult to bridge such a large development gap in a few hundred years" (pg. 259). On the same page in a cotton candy/candy apple moment they quote from John Lennon's quaint song, "Imagine", "I hope some day you'll join us, And the world will live as one". Our history lessons are painfully distinct from their wonder bread world and I invite Widdowson and Howard to instead meditate on Buffy Sainte Marie's superior anthem "The Big Ones Get Away". Every Indigenous change agent recognizes Buffy Sainte Marie's dedication to revolutionary change. Her lyrics from that song; "Money junkies hire all the smart ones" and "If the bad guys don't get you Baby, then the good guys will", are far more informative to Indigenous people then any words writers such as Flanagan, Widdowson and Howard, and anything they could ever string together in their quest to legitimize a world dominated by white privilege. Wesley-Esquimaux (2009) in a recent review of Widdowson's book writes that the book highlights a disturbing trend on what is becoming acceptable academic literature where a litany of "hatred and conjecture [is allowed to] re-enter the doors of tolerance and respect". Gerald Taiaiake Alfred (2009) in a 'wise guy' style also reviews this author and titles his commentary "Redressing Racist Academics, Or, Put your Clothes Back On, Please!" He addresses the intellectual inadequacy, hatred and contempt that has permeated Canadian media (especially misinformed, ignorant and arrogant writers such as the National Post's Jonathan Kay (2009), and the Globe's Margaret Wente) as inexcusable in academia. Hey, Jonathan getting rid of Third World conditions in First Nations requires rational dialogues on land and resource sharing and concepts like homelands as opposed to refugee camps (reserves) (01/16/09). A fairer analysis on the inequities of the Canadian state is provided by "A Fair Country: Telling Truths About Canada" by John Ralston Saul (2009). This author (Koptie), on reading Colin Tatz's 2003 book titled, "With Intent to Destroy: Reflecting on Genocide", would suggest it to wasting valuable intellectual time reading those colonial clowns, Flanagan, Widdowson and Howard, Kay and Wente. All Indigenous scholars need to offer rigorous challenges to the tired ideology coming out of Alberta, a major part of the new frontier of resource plunder and anti-Indigenous politics and policies for which Flanagan, Widdowson and Howard run the alibis.

A loss of obligation seven generations forward generated massive damage to the overall well being of our planet. The First Peoples plight has become a global experience where human populations are extinguishable in the name of wealth, just as the land, water and air that sustains them can be destroyed. The "capitalistic minority" of the planet profit from stealing wealth from "plunder zones" around the globe, from lands, which are generally occupied by Indigenous peoples. The real story of drunkenness is the inebriation of greed and hatred we find within the never-ending party of consumerism and acquisition (Maracle, 2009). The spiritual disconnect from interdependency that has infected humanity is poorly studied, and hidden under convenient language that quickly dismisses any impact on people, place and spirit. First Peoples must sustain a framework of Indigenous Knowledge that can bring back our sense of time and place. These teachings lay dormant in the narratives that once revived, will inspire us seven generations into the future. It is our role as Indigenous people to offer alternative perspectives on survival that will create new pathways from those taken for the past

500 years that have caused misery to most of the people on earth. If we were to turn the basic need pyramid upside down for ourselves, we would recognize the self-actualized existence the Creator has already provided for us. We would take only what we need out of a sense of graciousness, caring and sharing in order to not adversely impact those from whom we borrow our time and use of the land. We own nothing but a series of life sustaining relationships with all our relations. The Haudensaunee Thanksgiving Prayer is the most coherent spiritual directive, calling for a good mind and good life. To hear Mohawk Elder Tom Porter recite this code of conduct for all humanity reminds us that we are truly all one creation.

Geertz (2000) tells us that Thomas Kuhn has a wall hanging with the saying “God Save This Paradigm”, as a reminder of the need to challenge the entrenched notions of the cultural superiority of Western civilizations from the past several centuries. Kuhn called for “socio-historical science studies” to resist the trends of “subjective, irrational, and mob psychology” (p.166). He observes the tendency of historians, economists, anthropologists, science writers as well as philosophers, and the fields of religion, art, literature, law, and political thought to alternate between long periods of “normal” stability and short bursts of revolutionary upheaval. The past century gave us feminism, the end of modernity, New Age mysticism, the decline of Western hegemony and skepticism of rapid technological change (Geertz, 2000: 165). These events were foreshadowed in Kuhn’s writing in the 1950-60’s, and provide a way of viewing upheaval by shifting our consciousness to reevaluate the socio-historical roots of oppression and domination. Kuhn’s also comments on how day-to-day experiences impact our sense of the acculturation process and adaptation to a sometimes unfriendly and unsafe dominant culture, as well as the resistance, resentment and rebellion associated with being “the other.”

The American novelist, playwright, and essayist, James Baldwin (1955), tells a story, “Stranger in the Village” that triggered a personal identity crisis. When he visited a small Swiss village just after World War Two, children unaccustomed to seeing an African-American man found him “a sight” and called out “Neger, Neger” (p.1). He states he was “far too shocked to have any real reaction” other than the awkward smile one learns in the presence of ignorance and arrogance when a return sensitivity lesson is impractical (p. 1). His essay is a remarkable example of cultural relativism and how culturally derived categories can evolve into folklore, here the curse word Nigger. Baldwin (1955), traces this imposed identification to the tragic socio-historical remnants of slavery suggesting; “the history of the American Negro is unique also in this, that the question of his humanity, and his rights therefore as a human being, became a burning one for several generations of American, so burning a question that ultimately became one of those used to divide the Nation” (p. 4). Baldwin argues that Americans created this abstraction, which then became a spectacle to support their heritage of “white supremacy”. White supremacy according to Baldwin rests on the myth that “white men are the creators of civilization; the only one that matters, (all previous civilizations are simply contributions) and therefore they are civilization’s guardian and defender” (p. 5). This essay written in 1955 could be an editorial today and it ends with a prophetic statement regarding the “foolish and dreadful” denial of history in America, “the world is white no longer and it will never be white again” (Baldwin,1955: p. 6). Barak Obama ascension to the ‘White House’ in 2009 begins a new narrative for future generations of mislabeled humanity.

Clifford Geertz’s essay, “The Uses of Diversity, A Reflection on Ethnocentrism” has a reference to the Levi Strauss’ (1985) concept of “relative uncommunicability”. This concept was used to describe the dangers of ethnocentrism being “partially or totally insensitive to other values” and not recognizing that other cultures carry traditional values that maintain their place in the world they identify as their culture space. Ethnocentrism is not presented as an illusion that all humans would live in a world “whose cultures were all passionately fond of one another, in such confusion that each would lose any attraction it could have for the others and its own reason for existing” (Geertz 2000: p. 70). Warfare, economic upheavals, loss of empire and more recently environmental decline cause us to cling to core values to help us cope with the “state of the world” as we experience it and these realities. If we live in a collage, as Geertz (2000), suggests, or a quilt as Moorhouse suggests, we must arrange the elements of what is vital to us to come to a sense of agreement and commitment that can lead us to peace, harmony and commonality. He calls for “the moving away from to-each-his- own indifferentism, dismissing it is as charming, lovely even as [Pow-Wows], but inconsequential” (p. 87). As we look to the 21st century we are confronted with historic legacies of chronic misunderstanding and the rampant ethnocentrism of the 19th and 20th centuries. Diversity is a fact in contemporary times, and deciding if it is to in fact lessen cultural distance or remain a source of conflict becomes our modern challenge (Berry et al., 2003).

The moral issues of ethnocentrism in narrative form are found in “The Case of the Drunken Indian and the Kidney Machine” (Geertz, 2000: pp. 79-80). I found this story an excellent representation of the profound moral issues around alcohol and drinking patterns in First Nations populations. I have many personal experiences of discrimination, humiliation and shame around alcohol. My ex-wife’s mother initially rejected our relationship because “Indian men drink and beat their women” and in my first job interview out of university in 1980 I was asked if “I was an Indian and if I drank?” In 1984 I was employed

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with the Catholic Children's Aid Society of Metropolitan Toronto as a First Nations child welfare worker. I was asked in the lunchroom one day, "Why do Indians drink?" My reaction was somewhat belligerent, "Wait a minute, you mean you have a Masters of Social Work in Canada and do not know why Indians drink?" I was the one called into the manager's office for being insensitive. I never had lunch in that building again because it came to be a constant reminder of being an outsider in a culturally unsafe working environment.

I offer these stories of discrimination against Native man in a dominant white culture as a lead to "The Case of the Drunken Indian and the Kidney Machine". It is a story from an anthropologist from the southwestern United States who presented it as a representation of the huge cultural gap between medical staff and the Indian patients that presented for treatment at a local tribal health clinic. In a time of scarce health care resources, long waiting lists and costs, the staff at a medical clinic are shocked by an Indian man, who after gaining access to a kidney dialysis machine refused to stop drinking or control his drinking; he sees the treatments, which he never missed, as helping him live longer. His position was that yes, he had been a "drunken Indian" for some time and he intended to keep drinking as long as they could keep him alive. The conflicting moral issue for medical personnel around someone taking a healing treatment spot from others without the prospect of improvement in their quality of life was perplexing. He did die of complications from alcohol abuse. His story is more a representation the Spirit of Alcohol (Duran, 1995) and the sad relationship developed historically with alcohol that eventually took on a life of its own. The chronic lack of treatment, prevention programming, and harm reduction services in First Nations communities do not allow strong intervention in a cycle that has become intergenerational. I have an expression for those who refuse to help someone because they blame the victim for their inability to make choices or changes to their circumstances, "You are punishing him/her for living like an Indian." The normalization of dangerous drinking patterns such as binge drinking and other substance abuse problems to cope with life stresses in First Nations populations has become an historic legacy that seems to belie change and healing. Therefore this expression, albeit awful and racist, holds its own sad truths.

I return to our dilemma of adapting to modern times. We are ultimately left swinging between the ignorance and arrogance of the dominant culture, and our inability to create deep sustainable change at the ground level of our communities. We are waiting for history and the government to solve the hatred, jealousy, and greed of the past 500 years and alleviate our suffering. The metaphor or icon of the drunken Indian opens many avenues for further research. For me, understanding the role of alcohol in colonization is helped by a circus metaphor. Colonized people are the performers in this circus and social scientists represent P.T. Barnum, who is looking for the next oddity to draw a crowd, and to entertain the dominant culture (audience). Nothing draws a crowd better than a "drunken Indian" with all the inherent subjectivism, nihilism and incoherence. This is where this paper ends as a call for a fulsome restoration of the stories of Indigenous people around the world in the language of their ancestors and in a sequence that recovers those values that allowed members the dignity of recovery from pain and suffering. Stopping the dramatic performances of alcoholism, FASD/ARND, youth suicide, family violence and alcohol abuse requires ownership of a vast socio-historical truth that can also provide a context from which to design a national identity that is not a predatory side show. The First Peoples of Canada must lead the movement to reconciliation and restoration of a positive identity. Those who think violent confrontation is needed to put others in their place will only extract useless revenge and become the clowns in the colonization circus. Being raised on a traveling carnival and understanding the use of diversions to gain and sustain advantage I also know that you cannot perpetually fool everybody. The next 50 years and the future of Canada may well prove to be the "Greatest Show on Earth".

References

Alfred, T. (2009). *Review of "Disrobing the Aboriginal Industry"*. Posted January 16, 2009 http://www.taiaiake.com.

Amrani, N. (1993). *American Indian Women Poets: Women between the World*. New York, NY: Vantage Press.

Armitage, A. (1995). *Comparing the Policy of Aboriginal Assimilation, Australia, Canada, and New Zealand*. Vancouver, BC: UBC Press.

Baldwin, J. (1955). "Stranger in the Village" from *Notes of a Native Son*. Boston, MA: Beacon Press: Retrieved from http://www.uwm.edu/~gjay/Whiteness/stranger.htm.

Bear Heart, and M. Larkin (1996). *The Wind Is My Mother: The Life and Teachings of a Native American Shaman*. New York, NY: Berkley Books.

Berry, J., Mishra, R., and Tripathi, R., (2003). P*sychology in Human and Social Development: Lessons from Diverse Cultures*. Thousand Oaks, CA: Sage Books.

Blatchford, C. (2009). "It's no accident that what happens at Yellow Quill … happens." *Globe and Mail*, 23/02/08, Toronto, ON.

Boyden, B. (2005). *Three Day Road*. Toronto, ON: Viking Canada.

Brant-Castellano, M. (1987). Family Violence A Native Perspective. In *Canadian Psychiatric Association, Section on Native Mental Health*, Transcribed and Edited Proceedings of 1987 meeting, London. ON.

Chun, K.M. P.B. Organista and G. Marin (2003). *Acculturation, advances in theory, measurement, and applied research*.

Washington, DC: American Psychological Association.

Deer, T., (2005). *Mohawk Girls* (DVD), Revolution Pictures International and the National Film Board of Canada.

Duran, E. (2006). Healing the Soul Wound. New York, NY: Teachers College Press Columbia University.

Duran, E., and Duran, B., (1995). Native American Postcolonial Psychology. Albany, NY: State University Press.

Ellis, A. (1975). how to live with a neurotic. Hollywood, CA: Wilshire Book Company.

Gall, J., (1986). Systemantics, The Underground Text of Systems Lore, How Systems Really Work and How They Fail. Ann Arbor, MI: The General Systemantics Press.

Gall, J. (1975). Systemantics, How Systems Work and Especially How They Fail. New York, NY: Pocket Books.

Geertz, C. (2000). Imbalancing act: Jerome Bruner's cultural psychology. In *Available Light* (pp.187-202). Princeton, NJ: Princeton University Press.

Gore, A. (2006) *Inconvenient Truths: A Global Warning* (DVD), Paramount Pictures.

Hanks, J., (1996-1997). *Lucian and Jane Hanks fonds: M 8458, M 8078, M4387*. Glenbow Museum, Cargary. Retrieved from http://www.glenbow.org/collections/findingAids/archtm/hanks.cfm.

Hanks, L., and Hanks, J. (1950). *Tribe Under Trust: A Study of the Blackfoot Reserve of Alberta*. Toronto, ON: University of Toronto Press.

Hercz, R. (2007). The Rat Trap, Why Canada's drug policy won't check addiction. Toronto ON: *The Walrus*, December 2007 Volume 4 Issue 10.

Higham, C. (2000). *Noble, Wretched, and Redeemable, Protestant Missionaries to the Indians in Canada and the United States, 1820-1900*. Albuquerque, NM: University of New Mexico Press.

Hoffman, E. (1988). *The Right to be Human: A Biography of Abraham Maslow*. New York, NY: Jeremy P. Tarcher, Inc.

Kay, J. (2009). Yellow Quill, and the folly of aboriginal "sentencing circles". Posted January 16, 2009, Toronto, ON: *National Post*.

King, M. (1963). *Why We Can't Wait*. New York NY: Signet Classics.

Korzybski, A. (1933). *Science and Sanity*. Garden City, NJ: Country Life Press.

Maracle, L., (2009). *Lectures, Aboriginal Non-Fiction Writing*. University of Toronto.

Maslow, A. (1979). *The Journals of A.H. Maslow, Volumes 1 and 2*. California: Brooks /Cole Publishing.

Miller, A. (1990). *For your own good, hidden cruelty in child-rearing and the roots of violence*. New York, NY: The Noonday Press.

Moorhouse, J. (1995). *How to Make an American Quilt*, Universal Pictures USA.

Power, S. (2002). *A Problem from Hell, America and the Age of Genocide*. New York, NY: Harper Perennial.

Rapp, C. (1998). *The Strengths Model: Case Management with People Suffering from Severe and Persistent Mental Illness*. New York, NY: Oxford University Press.

Sainte Marie, B., (1996). *The Big Ones Get Away*. Retrieved from http://www.slyrics.com/songs/s/saintemariebuffy5336/thebigonesgetaway223223. Saul, J. (2009). A Fair Country: Telling Truths About Canada. Toronto, ON: Viking Canada.

Selekman, M. (2002). *Living on the razor's edge, solution-oriented brief family therapy with self-harming adolescents.* New York, NY: W. W. Norton & Company.

Smith, L. (2006). *Decolonizing Methodologies: Research And Indigenous Peoples*. New York, NY: Zed Books.

Tatz, C. (2003). *With intent to destroy: reflecting on genocide*. Verso: London, UK.

Thoms, J. (2007). *Leading an Extraordinary Life: Wise Practices for an HIV prevention campaign with Two Spirited men*. Toronto, ON: 2-Spirited People of The 1st Nations.

Trudell, John (2004). *Trudell: The Movie*, Big Buck Releasing, USA.

Walkem, A. and Bruce, H. (2003). *Box of Treasures or Empty Box?* Penticton, BC: Theytus Books.

Wesley-Esquimaux, C. and M. Smolewski, (2004). *Historic Trauma and Aboriginal Healing*. Ottawa, ON: Aboriginal Healing Foundation Research Series.

Wesley-Esquimaux, C., (2009). *Lectures on Aboriginal Mental Health*, Introduction to Aboriginal Studies, University of Toronto, Toronto, ON.

Widdowson, F. and Howard, A. (2009). *Disrobing the Aboriginal Industry: The Deception Behind Indigenous Cultural Preservation*. Montreal, QC: McGill-Queens University Press.

Yellowhorse-Braveheart, M, and DeBruyn, L. (1996). *The American Holocaust: Healing Historical Unresolved Grief.* Unpublished paper, Retrieved from http://www.class.uidaho.edu/engl504trauma/Braveheart.pdf.

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First Peoples Child & Family Review
A Journal on Innovation and Best Practices in Aboriginal Child Welfare Administration, Research, Policy & Practice
Volume 4, Number 1, 2009, pp. 80-88

COMMENTARY: Knowledge Mobilization in the Real World - Seeking Wisdom

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What is it that keeps us from acting on knowledge that we believe to be true? Over the years, mankind has derived many different forms of knowledge from science, from experience, and from divine revelation. We have applied some forms, especially in the natural sciences, to immense benefit to humankind, but other forms, especially in the human sciences, seem more difficult to apply. In the more recent past, we have had the benefit of considerable research to help us better understand how many of our societal problems are rooted in fundamental inequalities in our society. This polemic will focus important considerations in our search for better ways to serve our brothers and sisters. These include our knowledge of the social determinants of health, attachment theory, childhood resiliency, the impact of poverty, racism and its accompanying oppression. Few can deny that these are important factors in the development of healthy families that can form and nurture healthy and productive members of our society. Their relevance to the world of program and services seem obvious, yet they are remarkably elusive in their application I do not have easy answers to this conundrum, but I do wish to pose some provocative questions that will hopefully encourage a deeper reflection on these matters and open our minds to new possibilities that can assist us in pursuing their application Ultimately, if we define wisdom as the ability to put knowledge into purposeful action, we may even come closer to achieving wisdom.

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Social Determinants of Health

Richard Wilkinson, a leading researcher in the area of health inequities, has summarized the most critical social determinants:

> *Most important are three intensely social risk factors. First is low social status, which in this context is less a matter of low material living standards themselves than of their social consequences, such a feeling looked down upon, having an inferior position in the social hierarchy, and subordination (and therefore also a reduced ability to control one's circumstances and work). Second comes poor affiliations of all kinds, including lack of friends, being single, weak social networks, lack of involvement in community life, and so on ….Third comes early childhood experience which prepares us to deal with more conflict-ridden or more affiliative social environments.(As cited in Understanding the Social Determinants of Health, 2006)*

In his book Mind the Gap: Hierarchies, Health and Human Evolution Richard Wilkinson (2001) provides a novel approach to the question of inequity and perhaps inadvertently repeats an observation that Aboriginal people made in their initial encounters with the French, whom they considered barbaric because of their tolerance of poverty among them, something that no Aboriginal community would have accepted. Wilkinson points out that such inequality is new to our species, and began only when human societies became hierarchical about ten thousand years ago. In his penetrating analysis of patterns of health and disease, Wilkinson concludes that rather than relying on more police, prisons, social workers, or doctors, we must tackle the corrosive social effects of income differences in our society.

The May 2009 report of The Office of the Auditor General of Canada makes it clear that … "many First Nations face difficult socio-economic conditions. Some communities are in crisis. According to First Nations, these conditions present different challenges for First Nations than for mainstream society, but are not taken into account in the child welfare system. There is also a need to address the underlying causes of child welfare cases" (Chapter 4, p.16.)

The inevitable question for all of us is "What keeps us from acting on this knowledge?"

Structural Poverty

The social determinants of health indicate that poverty is a major contributor to many difficulties that families experience. Much of the literature on child welfare suggests that there is a high correlation between poverty and the likelihood of a child ending up in the child welfare system,

There is little doubt that children who are born in poor families, whose lives begin in an environment of deficiency and whose parents are preoccupied with the stresses of being able to provide decent accommodation, food, and security are at far greater risk than children whose parents are financially secure. Yet we have failed as a society to ensure that every child receives a basic level of sustenance, often blaming their parents for their deficiencies – all the while forgetting that these parents were raised within a similar situation. This is not to suggest that all poor children are doomed to the same eventuality, as some can overcome this burden at great personal effort, but we do know that there's a much higher possibility that this will be the case.

We have failed to deal with the broad structural problems that produce poverty. Inequity, marginalization, and powerlessness aggravate poor families' distress. There has been too great a reliance on traditional micro perspectives on children's well being. In other words, we make every effort to "fix" the people who present themselves for our help and too little to remedy the conditions that bring them to us. The capacities of families to meet their responsibilities to children are heavily influenced by the structural conditions available to parents such as sustaining jobs and being able to raise their children in adequate and affordable accommodations. Poor families are associated with high levels of transient living, sub-standard housing, lower education, poor nutrition, high rates of substance abuse and emotional disorders, and inadequate social support systems. In turn, poverty is the factor that places children at greatest social risk. Child poverty is not a directly causal factor, of course, but the correlation of poverty with other factors such as single parenthood, social isolation, and unsafe neighborhoods can enormously increase risks to children. While most poor families do not neglect their children, child welfare systems draw upon the families of the poor – the point raised by Kinjerski and Herbert (2000) and in the annual reports and in public forums by Alberta's Children's Advocate.

Leschied et al. (2003) summarize some important elements of the literature relating poverty to child outcomes reflects three major themes. The first theme relates child development directly to factors intrinsic to families living in poverty. These studies include factors such as nutrition and brain development suggesting poverty and, specifically, poor nutrition, places children at risk for later learning, behavioural and developmental challenges (Galler, Ramsay, Solimano & Lowell, 1983; Mustard, 1999; Tanner & Finn-Stevenson, 2002).

A second theme suggests that the instability of living arrangements and homelessness due to poverty place children at increased risk (Bassuk, 1996; Bassuk et. al., 1997). This may reflect the inability of children to receive consistent educational opportunities and parent(s) to develop a social network of support to buffer parental stress. Kowaleski-Jones (1999) suggest that families in 'deep poverty'5, have increasing difficulties exiting low income due low education levels and inadequate day care that are necessary to create a link to employment opportunities. This is of particular relevance to families involved with the child welfare system since, as noted by Trocmé et al. (2001) child maltreatment in Canada is particularly related to "… the major environmental conditions of which low socio-economic status and housing conditions play a significant role" (p. 29).

Thirdly, Avsion et al. (1994) provide a more encompassing framework within which to view the effects of poverty on children. They suggest that the 'pernicious' effects of poverty are such that the financial strain results in the combined effects of caregiver strain, lack of social support, lowered self-esteem and maternal distress resulting in childhood vulnerabilities reflected in both internal and external problems.

The extreme poverty of children in Canada requires no elaboration in this journal. The problems are even more serious in Aboriginal families. Wein and colleagues (2007), found in the Canadian Incidence Study that the most important reason for Aboriginal children coming into care was physical neglect, meaning that in many cases parents were unable to properly care for them because of their poverty, and the concomitant issues of poor housing and problems with addiction.

Of course, there is much we do not know about the effects of poverty and its interactivity with other factors. Why, for example, are some poor children successful while others fare poorly? What are the precise pathways or mechanisms by which poverty (income and other aspects of poverty) have positive or negative effects on children's

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development? What are the risk and protective factors for the physical and mental health (including chronic problems such as depression or substance abuse), and cognitive, linguistic, affective, and social development of children growing up in low-income families? How, in the context of poverty, do societal norms shape children's socio-emotional characteristics and, in turn, influence children's socio-emotional and cognitive development? How does poverty interact with other variables, such as family structure and family processes, or ethnic and cultural differences, resulting in particular child outcomes? How do social-ecological – including neighborhood, family, and peer group – factors affect the development of poor children? To what extent does geographical mobility due to economic needs influences the stability and quality of housing and schooling and, consequently, children's developmental trajectories? Which interventions are most effective in reversing these impacts? What is the optimal timing for interventions and under what conditions?

Having said this, there is much that we do know about the pernicious and ongoing effects of poverty on child and family life. The question is – do we have the will to do something about it?

Attachment Theory

We know that children who do not have the fortune to develop a sound attachment and secure base at an emotional level with the mother, especially in the womb and during the first year of life are at an immense disadvantage, one that can be difficult to recoup. Yet we too often fail to ensure that pregnant mothers are provided with the security they need to prepare themselves the most important job in the world, that of producing the next generation of human beings. Yet in spite of knowing that the social circumstances of children can determine their present and future health, knowing that the happiness and contentment and security of the mother has a huge effect on determining the future emotional and physical well-being of the child, knowing that we have a limited time and opportunity to ensure that young children are able to develop to the fullest extent, we continue to fail many of our children.

Nowhere is this more visible than in the world of Child Welfare which deals with children who are most likely to have experienced such losses; children who are most likely to have lacked the fundamental security and firm foundations that all of us depend upon to live rich and fruitful lives. Nowhere is this more likely to happen than with children whose basic needs for security, love, food, attention, and attachment have not been met. Nowhere is this more likely to occur with than with children who live with a series of unrelated caregivers, whose love and emotional attachment may be peripheral at best. Nowhere is this more likely to occur than for Aboriginal children who in addition to the burden that they carry as a result of their early backgrounds, have to carry the burden of losing their identity, their sense of self, and their connection to family, community and culture. The evidence seems clear that for too many of these children, life becomes a revolving door of renewed poverty, homelessness, addiction, institutional life in jails and mental health settings. This we know to be true. The question then becomes, why are we failing to address the fundamental root causes that produce such devastation upon our children and upon our world? Why are we are reluctant or unable or unwilling to act upon the information that we have. We continue to develop new information, new research and are probably the most researched people humanity has ever known. Some have defined wisdom as the ability to apply knowledge into practice. This is especially difficult today as we sift through massive amounts of information derived from the internet, magazines, books, blogs, and many other forms of media. The question is, when does such knowledge become wisdom? To what extent does all of this information serve to improve the human condition and the creation of a more egalitarian, humanistic and ultimately spiritual society that will attend to the needs of all of its members.

While this discussion is focused on the Indigenous people of Canada, it seems clear that Indigenous people everywhere are suffering. As a human race, we know that twenty percent of our members are consuming eighty percent of the world's resources. We know that we are devastating Mother Earth in our practices, fouling its waters, polluting its air. We know that there are fundamental racist and oppressive attitudes towards others, particularly towards those with a darker shade of skin. We know that many of our mainstream institutions depend upon a constant supply of such people to maintain their existence. Our courts, our legal systems, our police forces, our jails depend upon a constant and increasing supply to keep their jobs. Yet based on the evidence in this country and in the United States, we should by now have come to realize that the solutions do not lie in the arrest, processing, and incarceration of poor black men, poor Native men, and poor Hispanic men. The evidence seems clear that the solutions sought by the Bush administration and now likely the Harper administration will not address the problems and the issues that are ahead of us. The child welfare system is not too different. Were it not for poor Aboriginal families, it would be far smaller that it is today. Sadly, with growing immigration from African countries, I worry that we are following similar trends as in the US with Black children whose families are increasingly coming to the attention of the authorities

How did we get here? A Societal Conundrum

John Ralston Saul, when he wrote "Voltaire's Bastards", described how over many years, the common people had

given over the authority to their kings as being in the best position to make decisions or judgments on their behalf. This worked more or less well for many years, until the French Revolution decided that the people had had enough of a royalty that showed no concern for the people who were starving in the streets. Ralston Saul then speaks of a shift in thinking that assumed that such power could better be placed in the hands of those we might now call technocrats; highly educated individuals who were prepared to assume leadership roles in dealing with important social issues and develop solutions based on a their superior knowledge and competence. This then, would be our basis for our safety; the intelligence of others. In some ways, this resulted in positive outcomes, and in many western countries the foundation was set for the creation of fundamental safety net systems for the old, the poor, for the creation of health care systems that would cover everyone, the creation of educational systems that would be able to serve all those that were interested and so on. Yet even then, some worried about this assumption. Eduard Lindeman spoke eloquently at the end of the 19th century about

> *... Technologists and specialists insulating themselves from the folk process and becoming each in his own limited sphere, wise in particulars and ignorant in general. (Lindeman, 1948, p. 304)*

Many would agree that the health, education, legal, and social institutions that serve people are failing them, especially those that serve Aboriginal people, despite the outlay of immense expenditures of money, time and human resources. Some speak of the misery industry – that which lives off the misery of the poor and the oppressed. A phenomenon is not easy to discount. If one were to add up of the resources allocated to Aboriginal people in Canada, including direct and indirect services and benefits, it would surely add up to billions of dollars. The capacity of clients, communities, and front line service providers to influence and fundamentally, change the institutions that have taken control of the lives of Aboriginal people seems limited at best. In part, the continuing and inexorable growth of such institutions can be attributed to their inherent to preserve themselves at all costs. Like any organism, whatever else they aspire to, all humanly created institutions primarily wish to preserve themselves. To achieve this purpose, along with their many reasons for existence, institutions must be highly organized to achieve these with efficiency and effectiveness. While this may have advantages, not the least of which is that organizations could not function without them, there are some inevitable downsides. This calls for top down direction, precise procedural direction, rigid roles, and expectations in a highly organized bureaucracy, and loyalty to the top. Weber wrote of the evolution of an iron cage, a technically ordered, rigid, dehumanized society, when he speculated on the other future possibilities of industrial systems. Weber had a foreboding of an "iron cage" of bureaucracy and rationality, but he recognized that human beings are not mere subjects molded by socio-cultural forces. We are both creatures and creators of socio-cultural systems. Moreover, even in a socio-cultural system that increasingly institutionalizes and rewards goal oriented rational behavior in pursuit of wealth and material symbols of status there are other possibilities.

> *No one knows who will live in this cage in the future, or whether at the end of this tremendous development entirely new prophets will arise, or there will be a great rebirth of old ideas and ideals or, if neither, mechanized metrification embellished with a sort of convulsive self-importance. For of the last stage of this cultural development, it might well be truly said: 'Specialists without spirit, sensualists without heart; this nullity imagines that it has obtained a level of civilization never before achieved. (Elwell, Retrieved July 27, 2006)*

Even early social workers were becoming concerned about such a trend, as the organizational model became prevalent in the provision of social services.

> *Philanthropy is becoming a business and a profession, and social agencies have begun to shut away the layman from any active connection with their function, crushing him beneath a magnificent and thoroughly perfected machine.* (Winslow, 1915)

> *"Humanity is acquiring all the right technology for all the wrong reasons."* (Buckminster Fuller)

The formation of such systems and their imposition on Aboriginal people who valued consensus, mutual respect and obedience to leaders based on their integrity as opposed to values that promoted top down and imposed leadership, the imposed authority of rank and hierarchy, and structured obedience that could be reinforced by punishment has created an inherent value conflict that continues to this day.

The extension of these inherent attitudes can be transmitted to those who serve such institutions, and whose loyalty is integral to the achievement of organizational purposes. In other words, in any contest between the purposes of the institution – be it a Federal Ministry such as INAC, a provincial organization such as Corrections, a local service such as Education – staff at all levels know what has the highest call on their loyalty, and what the penalties are for even appearing to favour those whom the organization is mandated to serve. We can see this at times even in the interaction between child welfare systems that serve and support Aboriginal families and to protect their children, creating the potential for conflict when staff disagrees with agency policy.

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Aboriginal Mothers and Child Protection

Three recent studies about the experiences of Aboriginal mothers with the child welfare system in British Columbia, in Manitoba and one continuing study in Alberta raise critical information about the relationship of mainstream child welfare systems with the mothers. These studies are a powerful testament to the distance we have yet to travel in our work with Aboriginal families and their communities. This is not to imply that immense efforts are underway nor is it to denigrate the efforts of so many policy makers, program planners, and committed staff to improving the service system for Aboriginal people, who are still the primary client. Many efforts are underway to address the programmatic factors that contribute to the hemorrhage of Aboriginal children to the child welfare system, but these will take many years to have the desired effect. While important policy and legislative changes support greater autonomy for Aboriginal child welfare programs in the recent past, we are suggesting that this is an essential, but not sufficient condition for improving the lot of Aboriginal families in the short term.

For those who would deny the possibility of this being necessary, we need look no further than the experience of Aboriginal mothers in three of our provinces where the numbers of Aboriginal children in care are reaching epidemic proportions. These studies include Broken Promises in B.C. (Pivot Legal Society, 2009), Jumping through the Hoops in Manitoba (Bennett, 2009), and Broken Hearts in Alberta (source?). While we cannot generalize this information there are sufficient commonalities in the experience of Aboriginal mothers in three western provinces to suggest that this it calls for closer examination. The triangulation of data from three different settings adds credibility sufficient to serve as caution – just like a dying canary in a mine warns the miners of toxic gases that may soon overwhelm them.

The Broken Promises study attributes much of this experience to a parent's struggle with poverty, addiction, mental health issues, or family violence:

- **Poverty**: Inadequate income assistance rates, the lack of safe and affordable housing, costly public transit, and inaccessible childcare all negatively impact the ability of poor women to care for their children.
- **Mental health**: People with mental health diagnoses and/or learning disabilities face discrimination as parents. Additional supports would assist them in caring for their children.
- **Domestic violence**: Women survivors of violence are poorly supported and, at times, re-victimized by the child protection system, which sees them as making poor choices, and failing to protect their children.
- **Drug and alcohol use**: There is an urgent need for enhanced treatment and harm reduction options for mothers struggling with addiction.

The child protection system is purported to be oriented toward family supports and ensuring the best interests of the child. There have always been swings in the relative priority of family-centered versus child-centered practice , with the latter often following media driven crises when a child unfortunately dies while in care or under investigation. We now seem to be in that part of the cycle where we think it best to err in on the side of caution following extended periods of public criticism in each of these provinces, and this may well have a bearing on what on the face of it, seems to be abysmal social work practice with aboriginal families.

The following summarizes some more noteworthy findings that seem familiar in each of the reported jurisdictions.

- **The web of surveillance**: Mothers living in poverty are subject to a high degree of scrutiny by the Children's Ministries by other government ministries and by the public. As a result these mothers experience stress and distrust and may be reluctant to reach out for help in times of need, particularly when they believe that disclosing their personal difficulties could result in their worst fear – the removal of their children.
- **Transparency**: Parents are deprived of basic information related to their case at every stage of the child protection process. Being informed about the Ministry's concerns is crucial for parents to be able to take steps to improve their circumstances and work towards the return of their child. Parents reported that they were not informed that an investigation was underway, or of the steps they need to take to have their children returned. Despite the duty of social workers to keep parents informed about the status of their file and the plan for their child, mothers felt they were consistently uninformed and sometimes given misinformation.
- **Placements and visits**: Children taken into care were often placed far from their family, siblings, and community, often in culturally inappropriate homes. Parents and grandparents were also concerned about the low priority placed on ensuring visits with children, the way in which visits were supervised, and the lack of accountability when visits are cancelled. A number of parents are very upset about the quality of care their children are receiving and the Ministry's lack of responsiveness when they voice their concerns. The preservation of kinship ties and a child's attachment to the extended family was, in many cases, not observed.

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- **The role of the social worker**: Social workers must play a dual role that can be highly problematic in terms of their relationship with parents. They play a supportive role where they are expected to build trust with a parent and provide the appropriate services and resources. On the other hand, they are investigators who may eventually make the decision to apprehend or not return a child. These competing roles can impede trust or rapport between the parent and social worker. There is also a very high turnover rate among social workers, which creates a lack of continuity. Huge caseloads can make it impossible to respond quickly to changes in parents' lives or to appreciate the strides parents are making to address the Ministry's concerns.
- **The court system**: The Courts play an important role in the child protection system as decision-maker and reviewer of child protection cases. Parents describe the court system as not only overwhelming in its complexity, but also plagued with inordinate and unreasonable delays. Many parents reported that while they had legal representation they did not feel adequately informed of what to expect at court dates and often did not understand what had happened in court. Delays throughout the court process leave many parents feeling hopeless and unheard. The court system, intended as an oversight mechanism to ensure that child protection laws are being applied appropriately, is viewed by parents as doing too little too late.

Outcomes for Children

Taking children into government care in order to ensure their safety and well-being is not working. Outcomes for children coming out of the foster care system are devastating. The Broken Promises Report indicates that seventy-three percent of youth involved with the young offenders system in B.C. are also involved with the child protection system, only 21 percent of former youth in care graduate, compared with 78 percent of the general population, and that in B.C., young women who are in the permanent care of the province are four times more likely to become pregnant than other young women who have never been in care. When these children become parents, they disproportionately lose their own children to the foster care system. Sixty-five percent of the parents that took part in this study spent time in the foster care system themselves as children. While such statistics are not easily attainable in other provinces, it is not a stretch to conjecture that they would not vary greatly in the rest of Canada.

How Could this be Happening?

The inevitable question in my mind is how could a system established with the express purpose of supporting Aboriginal families and protecting their children commit such atrocities? While this is a difficult subject to raise in this country, could it be at least in part because of systemic racism to which many of us are blind. Lise Noel (cited in Henderson, 2000, p.29) reminds us that systemic colonization is grounded in intolerance. This intolerance comes from unconscious assumptions that underlie "normal institutional rules and collective reactions." It is a consequence of following these rules and accepting these reactions in everyday life. In systemic colonization, Noel suggests that no single source of oppression or demeaning can be assigned causal or moral primacy. These are imbedded in the consciousness of all and so ingrained in our day-to-day lives that if the oppressed cannot point to any single form of oppression, then the oppressor and his consciousness become invisible. There is little reason to believe that such attitudes are not deeply ingrained in child welfare as it is in most of Western society. Such attitudes will take a long time to change. Indeed, a superficial review of history might lead even the most optimistic of us to conclude otherwise.

Our challenge is to willing to confront our own contribution to the challenges encountered by Aboriginal families in dealing with complex institutions like child welfare and the court systems. This calls upon each of us to be prepared to look deep into our souls to root out the vestiges of racist attitudes that continue to confound our relationships. Young (cited in Henderson, 2000, p.30) poses a conundrum for those who belong to the dominant groups of society.

> *The oppressor has no apparent existence. Not only does he not identify himself as such, but also he is not even supposed to have his own reality. His presence is so immediate and dense and his universe coincides so fully with the Universe that he becomes invisible. Rarely seen, rarely named, he is unique nonetheless and having a full existence as the keeper of the word. He is the supreme programmer who confers various degrees of existence on those who are different from himself...as the embodiment of the universal, the dominator is also the only Subject, the Individual, who never being considered to belong to a particular group can study those impersonal categories of the population who pose a "problem", represent a "question", constitute a "case" or simply have a condition".*

The complexities involved in reconciliation with Aboriginal people by members of the dominant group are no simple matter. To support Aboriginal self-determination in the development of policies and practices that are in keeping with Aboriginal traditions and beliefs calls for an uncommon degree of humility and a high degree of receptivity to different ways of thinking. It also calls for us to look into our soul, and as Carl Jung stated "People will do anything, no

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matter how absurd, in order to avoid facing their own soul." What are we afraid to find if we look into our souls?

Looking Into Our Souls

What is it that stops us from fearlessly addressing issues fundamental to human dignity and respect for individuals?" I propose that it is a corroding fear that inhibits creativity and the purposeful use of relationship to support families and their children. Combine thus with leadership that is prone to overreaction and a tendency to engage in damage control for public relations purposes, and we create an environment that is not conducive to facing problems honestly and openly. Without transparency, we are unlikely to resolve our most critical problems, proceeding, like the White Rabbit in Lewis Carroll's book, Alice's Adventures in Wonderland, with great haste to get absolutely nowhere. A first step has to be an ability to acknowledge our mistakes and to learn from them, rather than to "massage' the truth in the vain hope of sustaining public confidence. My ongoing monitoring of crises in child welfare all over the Western world makes it clear to me that this is not working.

Our work in Alberta under the Knowledge Mobilization Initiative raises some compelling issues. Front line child welfare workers plead to have their leadership assume greater responsibility in educating the public about the realities of their work, and to acknowledge that they will never be able to avoid the occasional situation that occurs in spite of their best efforts. They hope for a work environment that will permit them to create healthy relationships with the families they serve, and are often blocked by procedural and technological barriers from giving these priority. Often, their leaders, having little or no understanding what they are trying to achieve on front lines, fail to provide them with sufficient flexibility to be creative in their response to the families they serve, leaving them with rigidly structured responses to complex situations in a perpetual fear of litigation and blame when matters go awry.

Families expect respect and dignity, and to be involved in the articulation of their problems and what to do about them. More often, they are subjected to a veritable army of helpers, each with their own specialty, who want only a small part of their lives. However, no one wants to hear his or her whole story – there is no time! It seems as if Aboriginal mothers are the most oppressed and diminished people in our society. Yet they are the most critical component of the child welfare system. How often do we ask them what they need? Moreover, when we do, as occurred in these studies, how often do we listen?

Aboriginal Communities have been very articulate about their vision. The challenge is to learn from joint efforts with Aboriginal communities that will not only create new insights, but results in knowledge that is readily applied to real world situations. The current project took up this challenge by aiming to build collaboration among child welfare stakeholders and Aboriginal communities to examine issues relating to child welfare in their communities and create innovative, effective and practical approaches to child welfare that are more in keeping with traditional Aboriginal worldviews and may contribute to reconciliation, healing and increased community capacity. Community meetings have revealed that:

- There is a clear understanding of the current and past issues and their impact on community and family life.
- To address these issues will call forth the strength of the people based on the continuity of their culture, kinship systems and tribal responsibilities.
- It is essential to institute a structure that supports kinship relational roles and responsibilities, as the continuity of kinship is the key to well-being and survival, and
- The basis of their identity.

While there is progress, the communities' views of services that would help them, with some exceptions they are still removed from prevalent models of practice

The More Things Change, the More they Remain the Same

Yet, review after review concludes that with improved training, technology, and procedures we can in fact declare that no child well ever die in care again. If we can find the right model, if we import another solution from elsewhere, if we make child welfare workers more accountable, if we can get more resources, if we can organize more efficiently and effectively, if we can generate the right form, if we can land on the right organizational model and so it goes. If anyone is interested, I still have an audio tape of a press conference held by Dr. Neil Weber in 1984 declaring that since Alberta Social Services and Community Health was decentralizing and regionalizing its service system we would never have another Richard Cardinal again. I cannot count the number of reorganizations that have taken place in Alberta since that time, and I can see that our colleagues in other places have followed the same philosophy. Many more re-organizations later, we still proclaim that this time we will get it right. So what is the primary emotion that lies underneath all these efforts to get things right – to ensure that the child welfare system will never again have to read the headlines that proclaim the death of another child that it was supposed to protect? I propose that it is FEAR.

In part, the broader environment hones our reactions. The Homeland Security organization in the United States reflects a growing trend, one that opts to deal with fear of attack from within and without by building fences It is a

return to building castles surrounded by moats or another Great Wall of China make us feel more secure. It is a fool's illusions. A recent conversation with a bio-chemical specialist from the U.S. revealed that all of these efforts are for naught. He described how by imbuing a small piece of blocking paper with a certain chemical that could be carried in your purse or wallet without attracting any attention, had sufficient force when dropped in the city water system to poison the entire water system and easily destroy all of it's inhabitants. How can we defend ourselves from such weapons? We give up basic freedoms when we subject ourselves in airports intrusive and ridiculous rules that keep expanding and building a security industry designed to make us feel safe. We live in a society where nearly half of all adults depend upon prescribed drugs to deal with their anxiety. I am told that anxiety is the most prevalent reason for the referral of children for mental health counseling. I hear people in all walks of life who are fearful of their employers and worry about the security of their jobs.

Our governments collude in raising alarm about growing crime with the public that is not supported by statistics. This does not mean that crime has disappeared. Native gangs in our major cities keep growing, spawned in jails that are populated alienated youth. This phenomenon will not go away until they belong to their communities, see a future for themselves and have hope for the future. This is the largest growing population in our country and it is a worrisome trend. However, will we really feel safer by hiring more police, sending more youth to court, and by filling our jails, an excellent training ground for future criminals? How long will it take to understand that the needs of these youth are rooted in those fundamental issues described earlier? If,, as my friend Will Campbell, a spiritual advisor with Native Counseling Services of Alberta tells me, seventy-five percent of the men that he deals with in the jails are products of the Child Welfare system, should we not take the time to reflect on what we're doing and think of a different way? Would it be so difficult as a starting point to ensure that young mothers are secure and protected while their child is in the womb and to help them lay the foundation for life for their little ones? Would it be so difficult to use our knowledge, technology, and resources, to ensure that all families have a basic level of subsistence, that no child goes hungry, that all families have a decent home that no child goes to school feeling insecure and rejected and unloved? Can we not ensure that the collective resources of our society be available to all of our children so they can grow into happy, fulfilled and productive citizens?

You may ask, what would you have us do? This is too complicated, too expensive, and too hard! But, is it really? If we have the will, we can produce the material resources, knowing that we will pay a much higher price down the road if we hesitate. We know how to create strong and resilient children. A child who has one person in their life who values them and respects them can makes all the difference between a failed life on the street or in jail, or the life of a strong, capable individual, better prepared to face life on life's terms. Is it so difficult to ensure that every child has one person? We know that a child who can contribute to the community will have more respect for that community, feel more attached to it, more loyal to it and will want to contributing to that community with a greater sense of self-respect and belonging. Is it so difficult to ensure that children can contribute something to their community, to their school, to their church? We know that children who have some form of spiritual or religious connection will do far better in life Is it so difficult to ensure that every child has that opportunity? We know that every child who has the opportunity to develop one talent, to have one thing at which they can say, "I am very good at this, I am a good dancer. I am guitar player. I am a good soccer player". Anything that gives the child a sense of competence will help prepare the child for life on life's terms. Is this so difficult? We know that children who have an opportunity to engage in organized recreation are far better prepared to live life on life's terms. The lessons learned about teamwork and socialization, respect for others, competition, channeled aggression are invaluable. A life lived on life's terms. If this is so simple, why can we not do it? Why do we have to keep searching for other solutions? Why do we keep tinkering around the edges? Why do we have so much trouble changing our minds in the face of so much evidence that what we do now is not working? The answers are clear and if we take this one step at a time and one child at a time, we can make a difference. The essence of child welfare has not changed very much over the past 200 years. We have to think about what is working and what is not. We need the courage to discard what is not working and do more of what does. Simple. The catch is that one of the hardest things to change is our minds. If we can do that, the rest is clear sailing.

The Right Path

I believe that we have lost our way. Carlos Castaneda asks his Shaman "How does one know if he is on the right path? The Shaman replies,

> *Any path is only a path, and there is no affront, to oneself or to others, in dropping it if that is what your heart tells you... Look at every path closely and deliberately. Try it as many times as you think necessary. Then ask yourself and yourself alone, one question... Does this path have a heart? If it does, the path is good; if it doesn't it is of no use.* (Carlos Castaneda, "The Teachings of Don Juan")

The question is for us, "Does our path have a heart?" I believe that we need to learn how to take the Red Road.

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When Aboriginal people speak of the red road, before acting one should always take their thinking from the mind, where it originates, carefully nurture the idea in our heart, and only then put it into practice in my experience, the wise ones, the elders, live this way. This could ensure that we are on the right path. My question, for our policy makers, for our politicians, for our leaders, for our administrators, for our practitioners, for our communities, for all of us who wish to serve, "Does our path have a heart?" As we develop new legislation, new policy, new standards, new ways of doing things, will we take the Red Road?

So, where do we go from here? I must confess that I do not have all of the answers. None of us do! However, I believe that between all of us together– clients, families, communities, front line staff, administrators, program planners, researchers and academics, policy makers, and politicians we do have all the answers.

We all have a different perspective depending on where we are. Nevertheless, none of us alone, like the blind men with the elephant, gets the whole picture. It is the same with the child welfare system. The only way that the blind men could begin to understand what an elephant looks like would have been to step back from it and describe to each other what they "see." It does not suffice to share each other's perspective and insist that it is the only valid one. We must be prepared to hear what others have to say if we are to understand their reality. This is the nub of the knowledge mobilization initiative in Alberta. It calls each of us to come together in a dialogue that can enrich the lives of our children, their families and their communities. If may seem complicated, but it does not have to be if we are but willing to be open to each other's truth.

References

Avison, W.R., Speechly, K.N., Thorpe, C.T., Gotlib, I.H., Rae Grant, N.I. & Turner, J. (1994). Single parenthood, poverty, and the health of mothers and children: A stress process analysis. In M.W. Rosenberg (ed.), *Health and Behaviour 1994: Papers and Proceedings*. Kingston, ON: Queen's University.

Bassuk, E.L., Rubin, L. & Lauriat, A. (1996). Characteristics of sheltered homeless families. *American Journal of Public Health*, 76, 1097 - 1101.

Bassuk, E.L., Buckner, J.C., Weinraub, L.F., Browen, A., Bassuk, S.S., Dawson, R. & Perloff, J. (1997). Homelessness in female-headed families: Childhood and adult risk and protective factors. *American Journal of Public Health*, 87(2), 241 - 248.

Bennett, M. (2009). *Jumping Through Hoops: A Manitoba Study Examining Experiences and Reflections of Aboriginal Mothers Involved with the Child Welfare and Legal Systems Respecting Child Protection Matters*. Report prepared for Ka Ni Kanichihk Inc. and the Steering Committee of the Family Court Diversion Project. Winnipeg, MB: Ka Ni Kanichihk Inc. Available online from http://www.fncaringsociety.com/projects/docs/FCDP_Final_Report_Bennett_2009.pdf.

Campbell, W. (Personal communication, December 2009).

Castenada, C. (1970). *The Teachings of Don Juan: A Yaqui Way of Knowledge*. Penguin Books.

Fuller, Buckminster from the Quotations page:
http://www.quotationspage.com/quote/23586.html
http://www.quotationspage.com/quote/34114.html

Galler, J.R., Ramsay, F., Solimano, G. & Lowell, W. (1983). The influence of early malnutrition on subsequent behavioural development: II. Classroom behavior. *Journal of the American Academy of Child Psychiatry*, 22, 16 - 22.

Henderson, J.Y. (2000). Context of the State of Nature. In *Reclaiming Indigenous Voice and Vision*, Marie Battiste (Ed). Vancouver, BC: UBC Press.

Kinjerski , Valerie, and Margot Herbert. 2000. Welfare Caseload Growth in Alberta: Connecting the Dots. Unpublished Document. Available online at http://www.acsw.ab.ca/publications/connecting_the_dots.zip/view.

Kowaleski-Jones, L. (1999). Welfare receipt and family structure: evaluating the effects on children's reading achievement. *Sociological Focus*, 32, 181-200.

Leschied, A.W. Chiodo, D. Whitehead, P. & Hurley, D. (2003). The Association of Poverty with Child Welfare Service and Child and Family Clinical Outcomes. The University of Western Ontario. London, Ontario. Available online at http://www.edu.uwo.ca/CAS/pdf/Child%20Poverty%20and%20Child%20Welfare%20Admissions%20Technical%20Report.pdf.

Lindeman, E. C. (1948). *Democracy and Social Work. Proceedings of the National Conference of Social Work*. New York: Columbia University Press.

Pivot Legal Society. (February, 2009). *Broken Promises: Parents Speak About B.C.'s Child Welfare System*. Available online at http://www.pivotlegal.org/pdfs/BrokenPromises.pdf.

Saul, J.R. (1995). *Voltaire's Bastards: The dictatorship of reason in the west*. Toronto: Viking.

Understanding the Social Determinants of Health. (May, 2006). A discussion paper from the Office of the Chief Medical Officer, Vancouver Island Health Authority. Available online at http://www.crd.bc.ca/reports/regionalplanning_/generalreports_/housingaffordability_/buildingthehousingaf_/miscellaneous_/understandingsociald/understanding_social_determinants_of_health_05082006.pdf.

Wien, F., Blackstock C. Loxley, J., & Trocmè, N. (2001). Keeping First Nations children at home: A few Federal policy changes could make a big difference. *First Peoples Child & Family Review*, 3(1), 10-14. Available online at http://www.fncfcs.com/pubs/vol3num1/Wien_Blackstock_Loxley_Trocme_pp10.pdf.

Wilkinson, R. (2001). *Mind the Gap: Hierarchies, Health and Human Evolution*. Yale University Press.

Winslow, E. (1915). Philanthropic Individualism. *Survey*, 34, 555.

First Peoples Child & Family Review
A Journal on Innovation and Best Practices in Aboriginal Child Welfare Administration, Research, Policy & Practice

Volume 4, Number 1, 2009, p. 89

THE FINAL WORD: After the Residential School Apology: Why All Canadians Should Care about a Racial Equality Case Before the Canadian Human Rights Commission

Cindy Blackstock, First Nations Child & Family Caring Society

There is no way around it – if you are a First Nations child on reserve in Canada you simply get less government funding for statutory child welfare services than other children even though there are more First Nations children in child welfare care now than at the height of residential school operations. The federal government has failed to fully address the inequalities even after leading experts, including the Auditor General of Canada, have called for action. The Department of Indian Affairs (INAC) has publicly acknowledged that it's outdated funding formula results in growing numbers of First Nations children being removed from their families and placed in child welfare care. The Auditor General recently found that the federal government's new child welfare funding approach also fails to ensure equity.

These factors resulted in the Assembly of First Nations and the First Nations Child and Family Caring Society of Canada filing a complaint with the Canadian Human Rights Commission (CHRC) in February of 2007 alleging that the federal government's under funding of First Nations child welfare amounts to racial discrimination under the Canadian Human Rights Act.

Given that equality is a fundamental Canadian value and legal principle, it should have been in the joint interests of the federal government and First Nations to have an independent body such as the Canadian Human Rights Commission hear the case on its merits, forthwith.

However, since the Complaint was filed, the federal government has refused mediation twice and raised countless technicalities in an apparent effort to delay or derail the adjudication process. The federal government has gone so far as to question the jurisdiction of the Canadian Human Rights Commission to hear the case and the fairness of the Commission's investigative process. INAC's actions in this case lie in sharp contrast to INAC Minister Strahl's vigorous and public promotion of the CHRC in other forums such as the United Nations.

Despite the federal government's objections, on September 30, 2009 the Canadian Human Rights Commission formally considered the myriad of technical arguments raised by the federal government and ruled that case should be referred to inquiry before the Canadian Human Rights tribunal to be heard on it's merits.

In the last few days we were advised that the federal government is applying to the Federal Court of Canada to request that the child welfare human rights case be dismissed. The federal government basically argues that since they do not provide funding for non Aboriginal child welfare (the province does), the fact that the federal government provides so much less to First Nations children is not discrimination. This type of logic would defy the common sense and values of many Canadians who believe that children should not be deprived equitable services because of racial origin. There was no need for this delay, as the Tribunal could have entertained any further technical objections of the federal government at the time of the hearing.

Most disappointingly, we do not even know who in the federal government is instructing the lawyers at the Department of Justice – is it Prime Minster Harper? Minister Strahl? As Canadians, we simply do not know who actually instructs legal counsel at the Department of Justice. This vagueness leaves open the question of accountability when fundamental questions of racial discrimination affecting vulnerable children are at hand.

As Canadians, we should expect that when the federal government finds out about government legislation or policies that discriminate against children on the basis of race, they should move immediately to correct the problem. The federal government has not done so in these circumstances. Let's all call on the Prime Minister to immediately allow this case to be heard by the Canadian Human Rights Commission on its merits.

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