The International Indigenous Policy Journal

Volume 6 | Issue 1 Article 5

January 2015

Long Time Overdue: An Examination of the Destructive Impacts of Policy and Legislation on Pregnant and Parenting Aboriginal Women and their Children

Cyndy Baskin
School of Social Work, Ryerson University, cbaskin@ryerson.ca

Carol Strike
Dalla Lana School of Public Health, University of Toronto, carol.strike@utoronto.ca

Bela McPherson
bmcpherson2172@yahoo.ca

Recommended Citation
Baskin, C. , Strike, C. , McPherson, B. (2015). Long Time Overdue: An Examination of the Destructive Impacts of Policy and Legislation on Pregnant and Parenting Aboriginal Women and their Children. *The International Indigenous Policy Journal,* 6(1).
DOI: 10.18584/iipj.2015.6.1.5

Long Time Overdue: An Examination of the Destructive Impacts of Policy and Legislation on Pregnant and Parenting Aboriginal Women and their Children

Abstract
Today, in Canada, Aboriginal peoples continue to experience marginalization, over representation in the child welfare system, and a higher prevalence of poverty and substance misuse challenges. These experiences affect for Aboriginal women in particular because of the oppressive experiences of systemic racism and discrimination they face, including legislation such as the Indian Act and the Child and Family Services Act, which directly targets them. This article is based on a research project conducted in Toronto, Ontario that implemented Aboriginal research methodologies to explore ways to increase collaboration between Aboriginal families, treatment counsellors, and child welfare workers. One significant theme that emerged out of this project was the concept of time as related to policy and legislation that negatively impact Aboriginal pregnant and/or parenting women. In this analysis, we focus on the concept of time as connected to four policy areas that emerged from the findings: historical trauma caused by discriminatory legislation, the family court system, the bureaucracy of child welfare, and the need for further research and long-term solutions.

Keywords
Aboriginal mothers, substance misuse treatment, child protection

Acknowledgments
Funding for this research project came from the Canadian Institute of Health Research. This article is dedicated to our Elder, the late JoAnn Kakekaish.

Long Time Overdue: An Examination of the Destructive Impacts of Policy and Legislation on Pregnant and Parenting Aboriginal Women and Their Children

According to the 2006 Census, there are now over one million Aboriginal[1] peoples (1,172,785) living in Canada, with Aboriginal women representing 51% of that population (Statistics Canada, 2008). Although Aboriginal women only represent 3% of the total female population in Canada, the population growth of girls is greater than that of the general female population (Elizabeth Fry, 2010a). This may be due in part to Aboriginal peoples having a younger population, as evident in the median age of 27 years old compared to 40 years old for the general Canadian population (Statistics Canada, 2008).

Aboriginal women's health status is far below that of Aboriginal men, demonstrating disadvantage created by the intersection of race and gender in their lives (Native Women's Association of Canada [NWAC], 2007). The statistics for Aboriginal women are worrisome with respect to experiences of violence, abuse, and death. Aboriginal women between the ages of 25 and 44 years old are 5 times more likely to die as a result of violence than non-Aboriginal women in Canada and are more likely than non-Aboriginal women to have experienced abuse (Chansonneuve, 2008; NWAC, 2007). A human rights report commissioned by Amnesty International (2004), titled the *Stolen Sisters* report, discussed the extensive discrimination and violence experienced by Aboriginal women. Following this report, the Native Women's Association of Canada (NWAC) documented over 600 missing or murdered Aboriginal women since the 1980s through their role in advocacy, research, education, and awareness initiatives (Amnesty International, 2004; NWAC, 2007).

Furthermore, from a social determinants of health perspective, Aboriginal women experience inequities, such as lower quality of housing, fewer employment opportunities, lower educational attainment, inadequate physical environments, lower socioeconomic status, and weaker social supports within communities (NWAC, 2007). In turn, these factors contribute to increased rates of substance misuse, mental health challenges, suicide, poverty, lack of safe and affordable housing, and barriers to opportunities that could increase socioeconomic standing. The oppressive experiences of systemic racism and sexism that Aboriginal women face, including in legislation such as the Indian Act and the Child and Family Services Act, is of significance to Aboriginal women who are pregnant and/or parenting while using substances (Elizabeth Fry, 2010b; Horejsi, Heavy Runner Craig, & Pablo 1992; NWAC, 2007; Salmon, 2010; Smith, Edwards, Varcoe, Martens, & Davies, 2006) because such legislation means that they lack self-determination and influence in policies that directly relate to them. According to Chandler and Lalonde (1998), community wellbeing appears to be related to self-government (particularly the involvement of women), control of education, and control of the policies and practices of health and social programs. Other research links wellbeing to people and communities who believe they are in control of their lives (Reading & Wien, 2013). Unfortunately, colonial

[1] The term Aboriginal in this article reflects a diversity of Indigenous expression that is grounded in the North American context, otherwise known as Turtle Island. In Canada, the term Aboriginal most often refers to any person, group, or community who identifies as having ancestry to First Nations, either Registered (or Status) Indians as defined by the Indian Act of Canada or non-status First Nations; Metis; or Inuit. Other terms commonly employed in the literature that may be reflected in this writing include Native, Native American, American Indian, First Peoples, Original Peoples, and Indigenous.

governments and institutions are not acting upon such evidence, resulting in unequal participation of Aboriginal people in political institutions that govern their fate (Reading & Wien, 2013).

This article is based on a research project entitled *Developing Collaborative Relationships Between Aboriginal Mothers, Substance Misuse Treatment Counsellors, and Child Welfare Workers* conducted in Toronto, Ontario from 2007 to 2010. The overall goal of the project was to explore and better understand the relationship dynamics between Aboriginal women and the various systems of care in which they become engaged along their journeys of substance misuse, mothering, and wellness. We explore an emergent theme of how time shapes and can undermine these relationships.

Within this project, we incorporated two important frameworks: anti-colonial theory and community-based research. We chose anti-colonial theory because it examines how colonization has affected Indigenous peoples, as well as the relationships that exist between colonized and colonizing peoples, from the worldview of Indigenous peoples (Baskin, 2011). Post-colonial theory also discusses resistance and decolonization. It "indicates a new way of thinking in which cultural, intellectual, economic, or political processes are seen to work together in the . . . dismantling of colonialism . . . by examining the intersection of ideas and institutions, knowledge and power" (Loomba, 1998, p. 45). We chose community-based research because it fits well with Aboriginal values of community control throughout the research process. Community-based research centres on areas of interest and concern to local peoples and ensures that multiplicities of voices are represented (Porsanger, 2004). The project received institutional ethical review from Ryerson University and the Centre for Addictions and Mental Health (CAMH). Group techniques, including storytelling circles and focus group discussions, were used to collect information.

Literature Review

In understanding what contributes to the negative statistics and poor socially determined health outcomes for Aboriginal women, it is imperative to acknowledge the historical and intergenerational impacts of colonialism on their lives. Colonization can be understood as the forced takeover of Turtle Island (North America) by French and British settlers in the 1500s, which signalled the beginning of troubling times for the original peoples of this part of the world (Miller, 2000). Colonialism brought disease, death, displacement through forced reserve settlement, legislated assimilation policies, residential schooling, damaging child welfare practices, and the ongoing marginalization of Aboriginal Peoples, especially women (Miller, 2000). It is this enduring colonial legacy that is widely understood as being a major contributor to the contemporary social ills that plague Aboriginal peoples (Bombay, Matheson, & Anisman, 2009; Chansonneuve, 2008; de Leeuw, Greenwood, & Cameron, 2010; Ordolis, 2007; Shepard, O'Neill & Guenette, 2006).

Intergenerational trauma, also referred to as historical trauma, is commonly understood, in the Aboriginal context, as the process by which stressful traumatic experiences from colonialism have been carried over from one generation of Aboriginal peoples to the next (Bombay et al., 2009), resulting in the breakdown of traditional Aboriginal kinship and family structures, impacting parenting across generations, and disrupting traditional systems of social support (Horejsi et al., 1992; Niccols, Dell, & Clarke, 2010; Rutman, Field, Jackson, Lundquist, & Callahan, 2005; Shepard et al., 2006; Thibodeau & Peigan, 2007). This is the current reality for many Aboriginal women, indicating the need for an

understanding of and sensitivity to the intergenerational legacy and ongoing impacts of colonialism on Aboriginal women's lives (Benoit,Carroll & Chaudhry, 2003; Chansonneuve, 2008; de Leeuw et al., 2010; Horejsi et al., 1992; Ordolis, 2007; Rutman et al., 2005; Shepard et al., 2006; Thibodeau & Peigan, 2007).

Women who use substances while pregnant or parenting not only have to face the day-to-day challenges of social stigma in our society, but their experiences are compounded by the prevalence of a shaming discourse within health care and judicial systems creating further barriers to accessing treatment. Substance use during pregnancy has become equated to child abuse—often resulting in the apprehension of children at birth or soon thereafter (Carter, 2002; Crowe-Salazar, 2009; Niccols et al., 2010; Rutman et al., 2005). In our project, one mother spoke for many when she stated, "because I had a record with them, my other children were in CAS, they came and apprehended my youngest one from the moment [of birth]."

One research project by Carter (2002) explained how women's substance use and their fear of punishment created uncomfortable relationships with healthcare provides, which resulted in the women being 4 times more likely to receive inadequate healthcare, increasing the risk of adverse events for both mother and child. Carter (2002) further noted how the pejorative attitudes of healthcare providers create overwhelming barriers for low-income, substance using pregnant women. For some time in the Aboriginal context, prevalence rates of fetal alcohol syndrome effects (FASE) were believed to be at a state of crisis compared to the general population; however, recent research has revealed that, in fact, no clear evidence exists that differentiates the rates of FASE between Aboriginal and non-Aboriginal children in Canada (Pacey, 2009; Salmon, 2010).

For mothers who use substances while pregnant and/or parenting, prevailing discourses present a dichotomous view of the wellbeing of children versus the wellbeing of mothers (Carter, 2002; Crowe-Salazar, 2009; Greaves & Poole, 2007; Rutman et al., 2005). This leads to social responses that prioritize the wellbeing of fetuses and children over mothers' wellbeing, thereby failing to address the root causes that perpetuate women's disadvantaged social locations that correlate with their substance misuse (Greaves & Poole, 2007). For instance, the work of Niccols, Dell, and Clarke (2010) points to how research has indicated serious social and economic challenges such as homelessness, lack of affordable housing, and the struggle to provide "stable and nurturing" environments for children as barriers to women's ability to parent. Along these same lines, Boyd (2007) pointed out, "poverty, rather than illegal drugs, has the most negative impact on fetal health and birth outcomes" (p. 17). Furthermore, punitive laws that persecute racialized women for essentially being poor, pregnant or mothering, and dependent on substances have been criticized for punishing women rather than protecting unborn children (Rutman et al., 2005).

Another theme discussed in the literature pertaining to substance-using women who are pregnant or parenting is the racialization of mothers (Crowe-Salazar, 2009). Women are often characterized by a "racialized" existence, which positions them as marginalized "others" and "bad mothers" (Gustafson, 2005). Surveillance data shows that the use of illegal drugs is similar across racial and class lines for women; however, it is poor and racialized women who are most likely to be criminalized for their use (Carter, 2002). The amount of attention that gets paid to targeting specific racialized populations of women through public health campaigns and prevention initiatives like FASE have been noted (Rutman

et al., 2005; Salmon, 2007; Salmon, 2010; Smith et al., 2006). Interestingly, Salmon (2007) points to a national Canadian survey that showed how problem drinking was more prevalent among White, wealthy and middle-class women with high levels of education; however, these surveillance data are not used to construct this population as a "social problem" or a threat to their children. Salmon (2007) goes on to note that, nevertheless, it is Aboriginal communities that have often been earmarked for great public surveillance of "risky" behaviors such as substance misuse.

Aboriginal peoples' experiences with the child welfare system often tell of troubling, inappropriate, discriminatory, and harmful interactions that have left deep scars on the memory, and contemporary reality, of Aboriginal peoples. In Canada, there are currently 3 times more Aboriginal children in the child welfare system today than the number of children in attendance at the height of the residential schools in the 1940s (Blackstock & Trocmé, 2005; de Leeuw et al., 2010; Salmon, 2010). This phenomenon, referred to as the "millennium scoop," relies on the same policies as child welfare in the decades proceeding the turn of the 21st century, despite small changes to the Child and Family Services Act (Sinclair, 2007).

The child welfare system has also been criticized for relying heavily on risk assessments that de-contextualize women's lived experiences and behaviors from their parenting abilities (Boyd, 2007). Weaver (2007) similarly noted this with regard to the questionnaire child welfare workers use to assess substance misuse: The questions appear to build a case against women rather than help them. Assessments of substance misuse do not distinguish between patterns of use that may result in children being in harm's way or neglected, and patterns of use where safe arrangements for children are set up. As a result, substance use itself becomes proof of child abuse and/or maltreatment (Rutman et al., 2005).

The practice of assessment by child welfare workers could be improved if the type of substance(s) used and the severity of use figured more prominently in determining risks and case planning (Grella, Hser, & Huang, 2006). Assessments have been said to be "out of sync" with the realities of substance using mothers (Rutman, Callahan & Swift, 2007). Rutman et al. (2007) have drawn distinct conclusions based on four qualitative studies that highlight concerns associated with risk assessments such as a focus on weaknesses instead of strengths, a demand for a fast and linear process of healing, identification of issues a woman must deal with thereby constructing these as being personal faults of the woman, and a lack of needed self-reflection processes that are beneficial to women with substance misuse challenges in moving towards health and wellbeing.

According to a 2004 United Nations report cited by Niccols, Dell, and Clarke (2010), "Engaging and retaining pregnant and parenting women in treatment requires collaboration between substance use treatment sectors, prenatal care, and child welfare . . . Ideally, services should be accessed through a single site" (p. 325). An integrated treatment program approach would include pregnancy, parenting, and child-related services and care in addition to a woman-centred treatment approach (Niccols, Dell, et al., 2010). Evaluations of integrated programs suggest positive outcomes for women and children, such as the reduction of substance misuse, improved parenting capacity, better child development outcomes, and improved mental health (Niccols, Dell, et al., 2010; Niccols, Dobbins, et al., 2010). One quantitative study by Grella et al. (2006) exploring the situations of mothers who were in substance misuse treatment and were involved with child welfare services found that those who were able to attend

treatment programs with their children and/or retained custody of their children during treatment had higher rates of program retention than those who did not have their children.

Methods

The project arose from an earlier capacity building project where Aboriginal mothers experiencing substance misuse and child welfare involvement identified the need to better understand the nature and potential to improve their relationships with child welfare and substance misuse treatment agencies. Based on their recommendations, we designed this study to capture data in Toronto, Canada during 2009 and 2010 using two methods: focus group discussions for substance misuse treatment counsellors and child welfare workers; and story-telling circles to collect data from mothers experiencing substance misuse and child welfare involvement. These qualitative methods are appropriate when trying to understand social interactions and processes. From inception to analyses and dissemination, the community was represented in this project by Aboriginal women from the following agencies: Jean Tweed Centre, Centre for Addiction and Mental Health (CAMH), Noojimawin Health Authority, Toronto Public Health, Aboriginal Legal Services, Council Fire, Native Child and Family Services of Toronto, Native Women's Resource Centre, Métis Nation of Ontario, and Ryerson University.

We looked to our Elder, Joann Kakekayash, to ensure that our practices and outcomes were consistent with Ontario Coalition of Aboriginal People (OCAP) principles.

To recruit substance misuse treatment counsellors and child welfare workers, Baskin, Strike, and/or McPherson attended staff meetings at CAMH, Jean Tweed, Native Child and Family Services of Toronto, and Metro Toronto Children's Aid Society. In these meetings they described the research project, answered questions, and handed out a study flyer with information regarding how to contact the team and volunteer to participate. A total of 11 drug and alcohol and 12 child welfare workers who had worked with an Aboriginal pregnant or parenting woman in Toronto in the last five years volunteered to participate and attended one of four focus group discussions. We recruited workers and conducted the focus groups before we recruited mothers as a way to demonstrate to mothers our commitment to their confidentiality.

To recruit mothers experiencing drug and alcohol problems and with child welfare involvement to participate in a storytelling circles, nine agencies (i.e., CAMH (Aboriginal Services), Jean Tweed, Toronto Council Fire, Anishnawbe Health Toronto, South Riverdale Community Health Centre, New Heights Community Centre, Aboriginal Head Start, The Meeting Place, and the Scarborough Storefront) assisted by posting flyers on notice boards, sending email messages to their listserv recipients, and handing out the flyers directly to clients. For the storytelling circles, 38 mothers who self-identified as Aboriginal (i.e., First Nations, Inuit, or Métis) and had been involved with a child protection agency and an addiction treatment facility in Toronto in the past five years attended one of five circles.

Before obtaining consent from participants, we followed a cultural protocol that represents the value of reciprocity by the offering of a traditional tobacco tie to those from whom we seek their experience and knowledge. Traditional Aboriginal teachings "reveal the cultural significance of tobacco as a spiritual and sacred entity that helps us to remember the importance of our reciprocal and interdependent relationship in the web of creation" (Michell, 1999, p. 3). Tobacco is a sacred medicine and is used in

ceremonial practices. It is used to seal an oath in almost all important functions, friendships, and agreements (Michell, 1999). When researchers extract stories and knowledge, they are taking something sacred from people and communities. Since the research process disrupts balance for these people and communities, we offered each participant a tobacco tie to restore balance. Following this ceremony, each participant was asked to read and sign a consent form. A research team member discussed issues related to mandatory reporting requirements related to any disclosure during the session about abuse and/or intentions to harm one's self or others. Also, we reminded participants that other than those reporting requirements, we would not disclose what was said in the groups to child welfare and/or drug treatment workers and/or mothers. We asked each participant to respect the confidentiality of other participants and not to disclose anything said during the discussions. After answering any questions, we asked the participants to sign the consent form. We believe our use of ceremony, method of obtaining consent, and clarity regarding reporting requirements provided an environment where participants could judge what and how they wished to disclose their thoughts, feelings, and experiences.

Each of the focus group discussions with substance misuse treatment counsellors and child welfare workers was opened by our Elder, JoAnn Kakekayash, who offered a prayer and traditional teaching. After these ceremonies, Strike and/or Baskin asked the counsellors or workers who participated to discuss their experiences, attitudes, opinions, and recommendations regarding (a) providing services to and any collaborative practice with women, children, and families experiencing drug and alcohol problems; and (b) collaboration between the treatment and child welfare systems.

For the story-telling circles with mothers experiencing substance misuse and child welfare involvement, our Elder, JoAnn Kakekayash, opened with a prayer and a teaching about the Anishnawbe medicine wheel. Following these ceremonies, women were asked by Baskin and/or McPherson to discuss their experiences, attitudes, opinions, and recommendations regarding involvement with child welfare and substance misuse treatment. For the story telling circles, we placed a 4 x 4 foot artistic rendition of the Anishnawbe medicine wheel teachings in the centre of the circle and women were asked to structure their remarks, if appropriate, in relation to the four directions. An eagle feather was passed from participant to participant along the circle and used to designate a turn to speak, thereby ensuring all had the opportunities to speak. At the end of each circle, a traditional closing was facilitated by our Elder. The women were provided with a feast, an honorarium, and compensation for childcare.

With the consent of the participants, all of the storytelling circles and focus group discussions were recorded and later transcribed verbatim. To ensure the confidentiality of the participants, only members of our team with no direct clinical roles had access to the transcripts. Other team members, including those working for child welfare agencies and substance use treatment programs only had access to excerpts and never knew who participated or what particular people had said.

We read, discussed, and condensed the transcripts to understand the key ideas that participants spoke about using thematic coding techniques. For this project overall, and also during the analyses, we were challenged to represent the cultural complexity of the Aboriginal population in Toronto. In light of these challenges, we decided to focus on the teachings from our Elder and the Anishawbe land on which we conducted our project. To understand the stories we were told, we were guided by the seven grandfather teachings of Wisdom, Respect, Humility, Love, Honesty, Bravery, and Truth to examine and explain factors (e.g., personal, interpersonal, and institutional) that influence how mothers, counsellors, and

workers understand and interact with each other. We read, discussed, and coded the transcripts based on these teachings and also identified emergent themes. Following the coding procedures, we condensed the content of the codes into analytic summaries with supporting data excerpts. To ensure rigor, we presented our coding structure and analytic summaries to the full team for comment, discussion, and suggestions for clarification and modification. In this sub-analysis, we focused on one of these emergent themes: time. Time was examined as it connected to six policy areas that emerged from the findings: historical trauma caused by discriminatory legislation, the criminalization of mothers who misuse substances, the targeting of mothers through public health campaigns, the family court system, the bureaucracy of child welfare, and the need for further research and long-term solutions.

Results

Historical Trauma: Time Does Not Heal All Wounds

According to the literature, research that has examined Aboriginal family experiences of the child welfare system describes the need for workers to develop a better understanding of the historical relationship of Aboriginal peoples with child welfare authorities (Horejsi et al., 1992) and the lack of trust that can occur on numerous levels for many Aboriginal peoples such as loss of trust in self, family, community, government, and in those seen as "outsiders" (Thibodeau & Peigan, 2007). A substance misuse treatment counsellor in our research project suggested that multi-generational apprehension of children contributes to mistrust:

> What does it mean for [a mother] to have her children taken away as she was taken away from her mother and her mother was taken away?

In our project, mothers spoke to the catastrophic impacts that historical trauma with child protection authorities have had on them and their families. As one mother said,

> So me and the Children's Aid, we don't get along because even to this day, my children were taken from me because of my past being rooted in that system.

This mother was referring to the fact that her children were involved with the Children's Aids Society (CAS) because, as a baby, she was apprehended by CAS from her parents. Another mother, who did not lose her children, but did have the unrelenting involvement of CAS in her life, shared,

> Because we have a family history, as soon as I have my child, they're at the hospital trying to take my kid or they want to know what I'm doing. My kids never got taken away from me, but it's just like they're constantly there. They never leave you alone and just because something happens in a family, it doesn't mean the next generation is going to continue on the same pattern.

As one drug treatment counsellor in this research project shared,

> If a woman has come from a life of oppression and has internalized oppression, to get to a place where she can say she likes herself, that could be a life-long journey.

Family Court System: Time Repeating Itself

Branding mothers who misuse substances as uncaring or abusive is not helpful. One mother captured this when speaking about reaching out to CAS for help:

> They acted like I was an abusive parent. They took my [child] from me.

She went on to say that her child later informed her,

> They're [CAS] telling me I have fetal alcohol spectrum . . . You drank when you were pregnant with me because you didn't care and ruined my life.

Another mother in our project discussed her view of the focus of CAS on apprehension and adoption over helping the family:

> I thought they were there to help people, not to grab their children and run, and the more I hear of them, the more I feel that they want to take as many kids as they can. They don't even want to wait a year or two to have them in their care before they want to adopt them out. They (CAS) were talking to [removed name] about adopting [removed child's name] out as soon as possible. You know that's not right. It's not right at all.

One mother, who was in CAS as a child, remarked on the long-term effects she endured and the length of time it is taking her to learn about who she is:

> I've not been clinically diagnosed with depression, but I have through periods of my life been dealing with abandonment issues and things like that . . . I struggle with Native spirituality because I was raised in a different family, a Christian family, the typical adoption. I'm slowly learning about my Native background and my history now. I'm struggling to have my own beliefs I guess. I also want to teach my [child] these beliefs too.

The child welfare system continues to be criticized for placing more emphasis on the removal of Aboriginal children, than towards addressing the root causes that impact Aboriginal mothers' ability to parent (Ordolis, 2007). As one mother candidly shared,

> I have four children who have been in the Children's Aid off and on most of their lives. The first time they went into CAS, I asked for their (CAS) help. Having four children, it's hard to get a babysitter when you want to go to rehab to get clean and I couldn't get any of my family to help me that way.

Sadly, this mother spent years involved with the courts, post apprehension, and she eventually lost her children to crown wardship.

Another mom also spoke about the risk she took in order to get help:

> I had to put them (my children) in Children's Aid to get treatment because I didn't have any family or anybody able to take them . . . That could have really backfired on me. I jumped through every hoop they told me to; I even said "how high?" . . . I was honest and genuine from

DOI: 10.18584/iipj.2015.6.1.5

> the beginning because they wouldn't have known I had a drug problem if I hadn't told them . . . But I know other people that were honest and it didn't work, they just got slammed.

Child welfare's narrow focus on protection, rather than prevention, creates policies that conflict with Aboriginal practices that aim to keep children in their families and communities. A Euro-Canadian worldview continues to be imposed upon Aboriginal people through governmental legislation, policies, and laws, which violates their right to self-determination and the fact that they have never relinquished their right to care for their children. As one mother explained,

> They (CAS) come in and they just snatch up their (the parent's) kids and think they can teach them a better way than their own parents. When they return them home, they're screwed up because there was nothing wrong with them in the first place. Just somebody decided that they didn't like the way they parented. There's many ways of parenting. Not everybody parents the same, but just because one worker decides that they don't like the way the client is raising their children, they have the right to come and snatch them.

High Bureaucratic Demands: Narrow Windows of Time

The demands of child protection work has been observed as drawing attention away from building relationships with mothers as part of the child welfare process. Time is short for the latter due to the high demand of bureaucratic documentation and investigative procedures (Maiter, Palmer, & Manji, 2006). In this project, CAS workers lamented that the bureaucracy of their work does not usually fit with the realities of the mothers and families that they service. As one worker explained,

> We're at the hospital. The mom has just given birth. They will be released the next day. This means we have six hours of working time to figure out a safe plan for the child. It's never smooth. Things can change very quickly like something might've been one way an hour ago, but suddenly changes, so you have to make very quick decisions on the spot. You have such a little bit of time to find everyone you need to find and talk to everyone that could possibly help you or help the mom out.

Another worker echoed this, stating,

> You can't get everything done that you want to do. There is so much external pressure on us from the Society and the hospital.

Thus, even when workers try to assess situations and allow for bonding time between the mother and newborn, they are faced with unrealistic demands from the child welfare and health care bureaucracies. The narrow parameters of time also influence the time allocated for women to recover and reunite with their children. Not having enough time also strains the resources of substance misuse treatment counsellors. As explained by one,

> For the women that we work with if they're using and the children get apprehended . . . we're like, "okay you got to be in court in five days," and you have to be able to pick up and get in a program and complete a program and then you can come out and see your kids. It's astronomical in terms of the human resources and time put into this. It's like that for us, so how

> can we expect the moms to complete these challenges in such a short amount of time? The whole thing is unrealistic.

This is certainly tied into the excessive focus on compliance regarding case management and child protection standards, which lead to huge administrative requirements and unreasonable demands upon Aboriginal child welfare agencies. According to the Commission to Promote Sustainable Child Welfare (CPSCW, 2011), "compliance measures tell us relatively little about the outcomes for children and families or of CAS services" (p. 40) and yet, according to a former child welfare worker, this is what takes up so much of their time:

> When I worked in child welfare, I had 35 children on my case load . . . I mean there's only so many hours in a day and all the requirements of the notes are really very stringent . . . so it was a six day a week job.

Time and compliance demands also influence the treatment approach for mothers engaged with the child welfare system. Substance misuse treatment counsellors reflected that, for mothers, the demands for compliance fail to reflect the process of recovery as they are only allotted short periods to time to begin this rehabilitation. As one stated,

> A three-week program to me is like putting your toe in the water. I don't know how these women are supposed to do this.

Clearly, the mothers are not given the same amount of time as the child welfare bureaucracy and yet it is the former who are expected to change.

Such power imbalances and disempowering practices must be closely examined in terms of the relationships between service providers and Aboriginal families and communities. There is already evidence in British Columbia that communities that have some self-governance, meaning control over services such as child and family services, health, and education, experience lower rates of youth suicide than those that do not (Lalonde, 2006). Does it not make sense, then, to put time and resources into what seems to be helping, rather than repeating the same interventions over and over again?

Long-Term Solutions: Re-evaluating Time

Viewing motherhood over the life course, substance misuse treatment counsellors in this research project acknowledged how identities begin to transform during the prenatal period:

> During the time of pregnancy, it's a transitional stage and you start to think about family and where you come from and who you are as a person and a mother, and I think a lot of the women I work with, are estranged from their culture so pregnancy can be a time for them to find out where they belong.

Mothers involved in this project also spoke to the need of an integrative treatment approach:

> I think that what the City of Toronto needs really is a family treatment centre. I had the opportunity to go into a treatment centre in the [United] States a number of years ago that

DOI: 10.18584/iipj.2015.6.1.5

> addressed the whole person, but also the whole family because the disease of addiction affects everyone in our family. It touches the lives of everyone that we love and I think that we really need to have a place where our children can come in with us so that we don't have to worry about where they are . . . That whole stress of your child being away from you would not be there, so we would be able to heal while there.

One mother, who agreed with the others, emphasized that when the topic of family treatment centres is discussed the talk typically focuses on the lack of funding and it has been discussed for a very long time with no results:

> I know that there have been talks about something like that for years, like almost 20 years, and here we go again. I've sat in circles over and over again and it's always the same people and it's always about money.

This concern was also raised by both substance misuse counsellors and child welfare workers who referred to the importance of beginning to "examine rules that are not working" and the need for "long-term policies that engage all parties" who are involved with women and their children.

Conclusion

This article is based on a research project that explored the relationships between Aboriginal mothers who misuse substances and the various systems of care with which they become engaged. Through group techniques, including storytelling circles and focus group discussions, the concept of time emerged as a significant theme. Time was then connected to the four policy areas that emerged from the findings: historical trauma caused by discriminatory legislation, the family court system, the bureaucracy of child welfare, and the need for long-term solutions embedded in policies.

As is evident in this article, only a handful of sources from the literature spoke about the issues of Aboriginal women's substance misuse and mothering (see Niccols, Dell, et al., 2010; Niccols, Dobbins et al., 2010; Rutman et al., 2005, 2007; Salmon, 2007, 2010). In the literature, authors who wrote from an Aboriginal context did not always have a gender specific analysis: Some content pertained to Aboriginal families and Aboriginal peoples more broadly. Aboriginal specific sources also tended to focus more on child welfare issues over substance misuse among pregnant and/or parenting Aboriginal women. Social determinants of health and colonialism were generally noted across a broad spectrum of Aboriginal peoples, rather than a specific focus on Aboriginal women who misuse substances, let alone those who do so *and* are pregnant and/or parenting.

When piecing the literature together, the need is great for supportive care and treatment for Aboriginal women's health and wellbeing when dealing with substance misuse while pregnant and/or parenting. What is missing is a contextual analysis and research that is specific to the relationship dynamics between Aboriginal women and the various systems of care with which they become engaged along their journeys of substance misuse, mothering, and wellness.

Colloquial sayings such as "time is precious," "it's about time," and "there's no time like the present" resonate within both the literature and the findings from our research project. Legislation, policies, and laws that aim to protect children are, at the same time, hurting Aboriginal mothers, families, and

communities. They also often create stress for child welfare workers and substance misuse treatment counsellors in that they confine them to unrealistic time constraints and create situations where workers enact the very barriers they identify as impeding their ability to assist Aboriginal mothers and their families.

The authors acknowledge that, based on a qualitative design, the findings reported may not necessarily be transferable to other mothers, workers, counsellors, or contexts. Given the group nature of data collection, some participants may have been reluctant to disclose all experiences. However, our discussions and storytelling sessions were passionate. Participants discussed emotional and painful topics, suggesting that our data reflects important issues and experiences. This is one of the few studies to recruit all these groups and provides insight to guide further exploration.

Several recommendations came from the project participants to assist policy makers and those who are designated to carry out those policies to make positive changes in the lives of Aboriginal women and their families. Of interest is the fact that the majority of the suggestions that came from all three of the populations involved in the project were in agreement about what needs to be done in terms of policy change. These recommendations include:

- Ensure that policies reflect the overall situation of families, including the environmental factors affecting them;
- Address the whole family as the recipient of services without pitting the needs of children against those of mothers;
- Provide space for mothers to learn healthy parenting according to Aboriginal worldviews and values in order to minimize the risk for apprehension;
- Acknowledge historic trauma and the intergenerational impacts caused by colonization upon women and families;
- Educate about and implement anti-oppressive, anti-racist, and anti-colonial ways of assisting families;
- Respect the complexity of the healing journey and the time it takes to travel along this path;
- Involve Aboriginal mothers in the development and evaluation of programs and services within child welfare and substance misuse treatment;
- Create treatment centres that address the whole family; and
- Develop an Aboriginal Family and Child Services Act that reflects Aboriginal worldviews and values.

Perhaps enough time has gone into research that highlights that legislation, such as the Indian Act and the Child and Family Services Act, are detrimental to Aboriginal mothers and their families. Perhaps it is time to stop repeating what is not working and put our time and resources into exploring what is, and

DOI: 10.18584/iipj.2015.6.1.5

what might be, of help. The participants in this research project have offered several beginning points to do so.

References

Amnesty International. (2004). *Stolen sisters: A human rights response to discrimination and violence against Indigenous women of Canada.* Retrieved from http://www.amnesty.ca/stolensisters/amr2000304.pdf

Baskin, C. (2011). *Strong helpers' teachings: The value of Indigenous knowledges in the helping professions.* Toronto: Canadian Scholars' Press.

Benoit, C., Carroll, D., & Chaudhry, M. (2003). In search of a healing place: Aboriginal women in Vancouver's downtown eastside. *Social Science & Medicine, 56*(4), 821 - 833. doi:10.1016/S0277-9536(02)00081-3

Blackstock, C., & Trocmé, N. (2005). Community-based child welfare for Aboriginal children: Supporting resilience through structural change. *Social Policy Journal of New Zealand, 24*, 12 - 33. Retrieved from http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/

Bombay, A., Matheson, K., & Anisman, H. (2009). Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *Journal of Aboriginal Health,* 6 - 47. Retrieved from http://www.naho.ca/jah

Boyd, S. (2007). The journey to compassionate care. In S. C. Boyd, & L. Marcellus (Eds.), *With child - Substance use during pregnancy: A woman-centred approach.* (pp. 10 - 19). Halifax: Fernwood Publishing.

Carter, C. S. (2002). Perinatal care for women who are addicted: Implications for empowerment. *Health and Social Work, 27*(3), 166 - 174. Retrieved from http://www.ingentaconnect.com

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

Chansonneuve, D. (2008). *A residential addictions treatment facility for Aboriginal women and their children in the city of Ottawa: A feasibility study - Final report.* Minwaashin Lodge. Retrieved from http://minlodge.com/images/Feasibility%20Study.pdf

Commission to Promote Sustainable Child Welfare (2011). *Aboriginal child welfare in Ontario – A discussion paper.* Retrieved from www.sustainingchildwelfare.ca

Crowe-Salazar, N. (2009). *Substance use during pregnancy and a women centered harm reduction approach: Challenging the mother and baby divide to support family well-being and the prevention of child maltreatment.* Retrieved from http://www.whitebearfirstnation.ca/Substance%20Use%20during%20Pregnancy%20and%20a%20Women%20Centered%20Harm%20Reduction%20Approach.pdf

de Leeuw, S., Greenwood, M., & Cameron, E. (2010). Deviant constructions: How governments preserve colonial narratives of addictions and poor mental health to intervene into the lives of

Indigenous children and families in Canada. *International Journal of Mental Health and Addiction, 8*(2), 282-295. doi: 10.1007/s11469-009-9225-1

Elizabeth Fry (2010a). *Aboriginal women: National Elizabeth Fry week 2010 – Fact sheets.* Retrieved from http://www.elizabethfry.ca/eweek2010e/factsht.htm

Elizabeth Fry (2010b). *Violence against women and children: National Elizabeth Fry week 2010 – Fact sheets.* Retrieved from http://www.elizabethfry.ca/eweek2010e/factsht.htm

Greaves, L., & Poole, N. (2007). Pregnancy, mothering and substance use: Toward a balanced response. In N. Poole & L. Greaves (Eds.), *Highs & lows: Canadian perspectives on women and substance use* (pp. 219 - 225). Toronto, ON: Centre for Addiction and Mental Health.

Grella, C. E., Hser, Y., & Huang, Y. (2006). Mothers in substance abuse treatment: Differences in characteristics based on involvement with child welfare services. *Child Abuse & Neglect, 30*(1), 55 - 73. doi: 10.1016/j.chiabu.2005.07.005

Gustafson, D. L. (2005). *Unbecoming mothers: The social construction of maternal absence*. NY: Routledge Press.

Horejsi, C., Heavy Runner Craig, B., & Pablo, J. (1992). Reactions by Native American parents to child protection agencies: Cultural and community factors. *Child Welfare, 71*(4), 329 - 340.

Lalonde, C. E. (2006). Identity formation and cultural resilience in Aboriginal communities. In R. J. Flynn, P. Dudding, & J. Barber (Eds.), Promoting resilience in child welfare (pp. 52 - 71). Ottawa: University of Ottawa Press.

Loomba, A. (1998). *Colonialism/postcolonialism: The new critical idiom*. New York: Routledge.

Maiter, S., Palmer, S., & Manji, S. (2006). Strengthening social worker-client relationships in child protective service: Addressing power imbalances and 'ruptured' relationships. *Qualitative Social Work, 5*(2), 167 - 186. doi:10.1177/1473325006064255

Michell, H. (1999). Pakitinasowin: Tobacco offerings in exchange for stories and the ethic of reciprocity in First Nations research. Retrieved from http://www.sifc.edu/Indian%20Studies/IndigenousThought/fall99/tobacco.htm

Miller, J. R. (2000). *Skyscrapers hide the heavens. A history of Indian–White relations in Canada.* Toronto, Canada: University of Toronto Press.

Native Women's Association of Canada (NWAC). (2007). *Social determinants of health and Canada's Aboriginal women – Submission by the Native Women's Association of Canada to the World Health Organization's Commission on the Social Determinants of Health.* Retrieved from http://www.nwac.ca/research/xxx-nwac-reports

Niccols, A., Dell, C. A., & Clarke, S. (2010). Treatment issues for Aboriginal mothers with substance use problems and their children. *International Journal of Mental Health and Addiction, 8*(2), 320 - 335. doi:10.1007/s11469-009-9255-8

Niccols, A., Dobbins, M., Sword, W., Smith, A., Henderson, J., & Milligan, K. (2010). A national survey of services for women with substance use issues and their children in Canada: Challenges for knowledge translation. *International Journal of Mental Health and Addiction, 8*(2), 310 - 319. doi: 10.1007/s11469-009-9267-4

Ordolis, E. (2007). A story of their own: Adolescent pregnancy and child welfare in Aboriginal communities. *First Peoples Child & Family Review, 3*(4), 30 - 41. Retrieved from http://www.fncfcs.com/publications/online-journal

Pacey, M. (2009). *Fetal alcohol syndrome & fetal alcohol spectrum disorder among Aboriginal peoples. A review of prevalence.* Prepared for the National Collaborating Centre For Aboriginal Health. Retrieved from http://www.nccah-ccnsa.ca/docs

Porsanger. J. (2004). *An essay about Indigenous methodology*. Retrieved from http://www.ub.uit.no

Reading, C. & Wien, F. (2013). Health inequalities and social determinants of Aboriginal peoples' health. Prince George, BC: National Collaborating Centre for Aboriginal Health. Retrieved from http://www.nccah-ccnsa.ca/Publications/Lists/Publications/Attachments/46/health_inequalities_EN_web.pdf

Rutman, D., Callahan, M., & Swift, K. (2007). Risk assessment and mothers who use substances: Contradictions in child welfare practice & policy. In N. Poole & L. Greaves (Eds.), *Highs & lows: Canadian perspectives on women and substance use* (pp. 269 - 282). Toronto, ON: Centre for Addiction and Mental Health.

Rutman, D., Field, B., Jackson, S., Lundquist, A., & Callahan, M. (2005). Perspectives of substance-using women and human service practitioners: Reflections from the margins. In D. L. Gustafson (Ed.), *Unbecoming mothers – The social production of maternal absence*. (pp. 227 - 249). New York: Haworth Clinical Practice Press.

Salmon, A. (2007). Beyond shame and blame: Aboriginal mothers and barriers to care. In N. Poole & L. Greaves (Eds.), *Highs & lows: Canadian perspectives on women and substance use* (pp. 227 - 235). Toronto, ON: Centre for Addiction and Mental Health.

Salmon, A. (2010). Aboriginal mothering, FASD prevention and the contestations of neoliberal citizenship. *Critical Public Health.* 1 - 14. doi: 10.1080/09581596.2010.530643

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. doi: 10.1007/s10447-005-9008-8

Sinclair, R. (2007). Identity lost and found: Lessons from the sixties scoop. *First Peoples Child and Family Review, 3*(1), 65 - 82.

Smith, D., Edwards, N., Varcoe, C., Martens, P. J., & Davies, B. (2006). Bringing safety and responsiveness into the forefront of care for pregnant and parenting Aboriginal people. *Advances in Nursing Science, 29*(2), E27 - E44. Retrieved from http://journals.lww.com

Statistics Canada. (2008). *2006 Census: Aboriginal peoples in Canada in 2006: Inuit, Métis and First Nations* (Catalogue number 97-558-XIE2006001). Retrieved from http://www12.statcan.ca/census-recensement/2006/as-sa/97-558/p2-eng.cfm

Thibodeau, S., & Peigan, F. N. (2007). Loss of trust among First Nation people: Implications when implementing child protection treatment initiatives. *First Peoples Child & Family Review, 3*(4), 50 - 58. Retrieved from http://www.fncfcs.com/publications/online-journal

Weaver, S. (2007). "Make it more welcome:" Best-practice child welfare work with substance-using mothers – Diminishing risks by promoting strengths. In S. C. Boyd, & L. Marcellus (Eds.), *With child - Substance use during pregnancy: A woman-centred approach.* (pp. 76 - 90). Halifax: Fernwood Publishing.