

Aboriginal Children, Young People, and Families

Policy Brief prepared for the Middle Childhood Initiative of
the National Children's Alliance

August 1, 2006



FIRST NATIONS
CHILD & FAMILY
CARING SOCIETY
OF CANADA



Table of Contents

Introduction	3
Opportunities to Advance Policy Solutions for Aboriginal Children, Youth and Families	5
1. Reconciliation: A Cornerstone of Change.....	6
2. In Home Support and Prevention Services in Child Welfare	7
3. Implementation of Jordan’s Principle.....	9
4. Supports for Children with FASD.....	10
5. Reducing the risk of Type 2 Diabetes in Aboriginal Children.....	11
List of Key Resources:	12

Aboriginal¹ Children, Young People, and Families Policy Brief prepared for the Middle Childhood Initiative of the National Children's Alliance

Introduction

Aboriginal people in Canada endure social and health conditions much worse than any other population in this country. Poor conditions including ill health, critical shortages of adequate housing, polluted water supplies or no running water at all, ineffective education, poverty, and family breakdown occur to a degree usually associated with third-world countries². The persistence of such social conditions in Canada, which ranks as the fifth best country in the world according to the United Nations Human Development Index, is unacceptable. Although there have been some positive gains in closing the gap in life chances in recent years such as increasing the life expectancy of Aboriginal peoples, there are many areas where the social exclusion of Aboriginal children is actually worsening. This paper sets out both a suggested process for engaging respectfully with Aboriginal communities to close the gap in life chances for Aboriginal children, youth, and families, as well as opportunities for the National Children's Alliance (NCA) and its members to actively engage with Aboriginal communities to implement promising policy solutions.

Aboriginal children in the middle childhood years comprise the largest proportion of the total Aboriginal population in Canada. Aboriginal children (5-14 years) make up over 25% of the First Nation population³, both urban⁴ and on-reserve. In developing responses to issues facing Aboriginal children aged 6-12, it must be understood that many Aboriginal cultural perspectives value interdependence and holism, meaning that caring for children based on discrete age categories (e.g.: early years, school years, youth) is viewed as artificial and runs the risk of negating the transitions through the life cycle which are viewed as critical in many Aboriginal cultures. This does not mean that Aboriginal peoples are not sensitive to the developmental needs of children but rather that their development was positioned within the entire life cycle of the child instead of looked at as discrete and finite categories with few transitions.

Funding for core services such as education, economic and social development, capital facilities and maintenance has decreased by almost 13% since 1999-2000. However,

¹ Aboriginal peoples in Canada represent diverse cultures and language groups. The term Aboriginal in this paper includes First Nations, Métis and Inuit peoples.

² Blackstock, Clarke, Cullen, D'Hondt, Formsma (2003) *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.

³ DIAND, Aboriginal Women: A Profile from the 2001 Census. (February, 2006).

⁴ 'Urban' references core areas with a minimum population density, as defined by Statistics Canada, usually with commercial, industrial areas and public services such as airports and parks. 'On reserve' references a defined geographical area under the Indian Act which is set aside for occupation by Indians or a Band of Indians. Currently, there is an increasing Aboriginal population that is urban, young, and living in lone parent families. 69% of Aboriginal peoples in Canada live off reserve, and 50% live in urban areas.

the cost of providing comparable services to Aboriginal people is higher than it is for non-Aboriginal people in light of the higher levels of needs arising from colonization⁵, which is driving higher social costs in many First Nations. Differing demographics are also factors: for example, First Nations have a different population distribution than other Canadians in that young people constitute the majority. The higher proportion of youth in the First Nations population means that costs associated with services to children and young people are proportionately higher than in the overall population. Moreover, research indicates that First Nations children resident on reserve receive negligible benefit from voluntary sector services which have typically not provided services to on reserve residents⁶. Taken together, inequitable federal funding for children's programs, a dearth of voluntary sector supports, and the higher need for services sets in play a situation where Aboriginal families are significantly disadvantaged in accessing services to care for their children.

Within this context of the overall inequity in service access experienced by Aboriginal children, youth, and families, children aged 6-12 are particularly disadvantaged as there are very few programs specifically targeted to the developmental and cultural needs of these children. Aboriginal children and youth face serious discrepancies in their experience of health and health care. Throughout the 1990's, for example, funding for programs targeted to urban Aboriginal children aged 6-12 years was cut.⁷ The lack of programs and services available to meet the needs of young Aboriginal children is unacceptable in a country where federal budget surpluses have been forecasted to be \$40 billion over the next three years.⁸

⁵Colonization here refers to a process that includes geographic incursion, socio-cultural dislocation, the establishment of external political control and economic dispossession, and the provision of low-level social services. See Frideres, J. (1983). *Native people in Canada: Contemporary conflicts*. Cited in M. Kelm (1998) *Colonizing bodies: Aboriginal health and healing in British Columbia, 1900-1950* (pp.295-296). Vancouver: UBC Press.

⁶ Nadjiwan & Blackstock (2003) *Caring across the boundaries: Promoting access to the voluntary sector resources for First Nations children and families report*. Ottawa: First Nations Child and Family Caring Society of Canada.

⁷ National Association of Friendship Centres (October, 2005). *The Impact of Aboriginal Friendship Centres Program on Increasing Canada's Productivity*, Brief to the Standing Committee on Finance.

⁸ Canadian Centre for Policy Alternatives. (2005). *Federal Fiscal Forecasting: Round 4: report to the House of Commons Standing Committee on Finance*. October, 24, 2005. Ottawa: CCPA.

Opportunities to Advance Policy Solutions for Aboriginal Children, Youth and Families

Community programs that support Aboriginal children and their families are critical to narrowing the gaps that exist between Aboriginal children and their non-Aboriginal counterparts. Research consistently indicates that the key to ensuring sustainable socio-economic outcomes for Aboriginal communities is to empower community based decision making in the design and delivery of programs that affect them and providing adequate and sustained resources to achieve them. First Nation, Inuit and Métis communities are in the best position to determine how to meet the needs of their children and families and the role of the voluntary sector is to support those decisions through advocacy, resource provision and sharing of knowledge and skills. An engaged sector, aware of the health needs of Aboriginal children and youth and committed to a collaborative process to improve health outcomes, could make a significant difference. There is a need to develop broad-based, strategic, and coordinated efforts—led by Aboriginal organizations—to advocate for public policy changes that will benefit child and youth health. National voluntary sector organizations could also help support the development of voluntary sector organizations at the community level.⁹

As there are numerous Aboriginal communities in Canada with different cultures, traditions, and languages it is critical to avoid rolling out national pan Aboriginal programs that too often fail to respect the diverse contexts and needs of children in these communities. As a national organization, the NCA should form respectful working relationships with national Aboriginal peoples' organizations and seek direction on what policy solutions, policies, or programs that they could consider supporting. By leveraging the strengths of both Aboriginal peoples' organizations and members of the NCA in policy and program advocacy a stronger platform is created to end the social exclusion of Aboriginal children and ensure that promising solutions are implemented for their benefit.

This paper will summarize a number of evidence based policy solutions developed by Aboriginal peoples where the NCA can take immediate steps to greatly improve the life-chances of Aboriginal children in their middle childhood years. The recommendations for action for each of these policy issues pertain to both urban and on reserve communities, and should be understood in this context. These issues include:

- The importance of reconciliation in optimizing outcomes for Aboriginal children and youth
- Funding for in home support and prevention services in child welfare on reserve;
- Immediate implementation of **Jordan's Principle**, a child-first jurisdictional dispute model;
- Supports to maintain children with FASD in their birth families;
- Reducing the risk of type 2 diabetes in First Nation children.

⁹ Many Hands, One Dream: New Perspectives on the Health of First Nations, Inuit and Métis children. www.manyhandeddream.ca.

1. Reconciliation: A Cornerstone of Change

Over the past twenty years, culturally appropriate services have been developed in order to better respond to the disproportionate risks faced by Aboriginal children. The efficacy of these services is uneven, with many limited to adaptations of conventional programs which too often assume cultural neutrality, and thus the overall effect can be one where the culturally appropriate adjustments are treated as accessories rather than fundamental program elements. Another missing element in the assessment of how culturally appropriate programs are, is that the fundamental values and assumptions of service systems and professions often goes unexamined, resulting in a missed opportunity to see if there were options for revising or improving professional values, pedagogy, and policy.

Recent movements in both child welfare and Aboriginal child health have actively engaged the professions of social work and health to better identify how the values, beliefs, and practices of these professions support and address the well being of Aboriginal children. These movements have now developed both processes and principles to guide fundamental change within the professions to better serve Aboriginal children. For more details, please review the resources available at *Reconciliation in Child Welfare: Touchstones of Hope for Indigenous Children, Youth and Families* (www.reconciliationmovement.org) and *Many Hands One Dream: Principles for a new perspective on the health of First Nations, Inuit and Métis children and youth* (www.manyhandsonedream.ca) to inform your own work.

Recommendation:

That organizations which influence policy or provide service and support to Aboriginal children and youth abide by the principles and recommendations of both the *Reconciliation in Child Welfare: Touchstones of Hope for Indigenous children, youth and families* and the *Many Hands One Dream: Principles for a New Perspective on the Health of First Nations, Inuit and Métis Children and Youth* documents and develop means of implementing these principles throughout their activities.

2. In Home Support and Prevention Services in Child Welfare

The present federal government funding methodology, known as Directive 20-1, Chapter 5 (hereinafter called the Directive), to support First Nations child and family service agencies to deliver child welfare services on reserve has been broadly criticized for encouraging the apprehension of First Nation children and placement in care. Whereas the Directive provides unlimited reimbursement for children admitted to foster, group or institutional care, the funding for agency operations (staff, buildings, policies, etc.) and in home supports to children and their families has been allocated to the operations portion of the formula and is a fixed amount based on exceeding population thresholds for status Indian children on reserve. There is no consideration of the needs of children in the calculation of the operations formula, so high needs communities receive the same amount as communities of lesser needs of similar size. Two independent reviews of operations formula found that there is very little funding for prevention services even for First Nations child and family service agencies which receive the full operations allotment. The end result is a dearth of funding to support First Nations families to keep their children safely at home and unlimited funds to remove them.

What results from the lack of support services to children and their families is a critical over-representation of First Nation children in the child welfare system. Research has reported that, as of May 2005, “one in ten First Nation children was in care, as opposed to one in 200 for other children”¹⁰, with the highest placement rate occurring for children in their middle childhood years.¹¹ The 2003 *Canadian Incidence Study on Reported Child Abuse and Neglect* (CIS-2003) found that the most prevalent factor for placing First Nation children in care was physical neglect related to poverty, poor housing, and substance abuse within the family. These key drivers for placing children in care are preventable, and it is important to note that two of the key drivers are outside of the control of First Nation parents to change. At the very least, adequate funding from the federal government for in home support services would decrease the number of children in the care of child welfare.

Child protection legislation in every province includes provisions for the delivery of services that result in the least disruption of the family unit. This has been determined to be in the best interests of children. The Supreme Court of Canada has determined that in issuing a warrant for the apprehension of a child the court must first determine that the best interests of the child dictate a temporary or permanent transfer of guardianship.¹² This determination relates to the capacity of parents to care for their children in that a resultant apprehension reflects that a parent is “unfit” to care for their child (ren). As discussed above, the causal factors for First Nation children being placed in care are outside parent’s control and have little to do with a parent’s direct ability to care for their child. The blocks are stacked against First Nations children and their parents from the outset.

¹⁰ First Nations Child and Family Caring Society of Canada, Annual Report 2004/05.

¹¹ Canadian Incidence Study of Reported Child Abuse and Neglect: Final Report, (2005).

¹² See *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, [1999] 3 S.C.R. 1123.

Crucial to the future of First Nation children is a “family-centered, family-preserving approach within a community-building framework and with much cultural content”.¹³ Continuing down a path that focuses on protection and apprehension will ultimately result in further increases in the numbers of First Nation children being placed in care, away from their families and communities.

Recommendation:

First Nation child welfare agencies must be adequately funded to deliver in home support and prevention services to First Nations children and their families in order to give children an equitable chance to stay safely in their homes.¹⁴¹⁵

¹³ Loxley, J. & DeRiviere, L. Promoting Community & Family Wellness: Least Disruptive Measures and Prevention, in Wen:De (2005).

¹⁴ For more information, and background to this recommendation, please access the Wen’de Report which can be found at the First Nation Child and Family Caring Society website, at www.fncaringsociety.com

¹⁵ For more information on how child welfare can better meet the needs of Aboriginal children please access the Reconciliation in Child Welfare: Touchstones of Hope for Indigenous children, youth and families report at www.reconciliationmovement.org

3. Implementation of Jordan's Principle

First Nation children who are status Indians are continuously caught in a quagmire of intergovernmental and interdepartmental jurisdictional disputes regarding responsibility to pay for the costs of care for First Nations children with special needs. Jordan was a child with a complex genetic disorder who was forced to spend his entire life in a hospital; not because of his illness, but because two federal departments could not reach a settlement as to which department would cover the costs to care for Jordan in a medically trained foster home. Many children like Jordan, are taken into care for the sole purpose of accessing necessary medical services and supports.

The average Canadian gets services from federal, provincial, and municipal governments at an amount that is almost two-and-a-half times greater than that received by First Nations.¹⁶ If Jordan had been a child off reserve, the entire per diem cost would have been covered by the non-Aboriginal child welfare agency with full reimbursement from the provincial government to the agency. The child's needs would have been put first. However, as lengthy negotiations regarding the costs of Jordan's care continued, Jordan sat and waited in an institutional setting which was void of the sights, senses, and sounds of a loving home.

An arrangement was finally reached concerning Jordan's care. Before Jordan left the hospital to move to his new home in his community, he pulled his breathing tube out accidentally and died. In Jordan's memory, we ask that the federal and provincial government adopt a 'child first' policy with regards to First Nation children. These children deserve equitable access to services and supports that are enjoyed by other Canadian children.

Recommendation:

That the federal and provincial governments immediately implement a 'child first' policy to ensure that First Nation children's needs are not sidelined as intergovernmental or interdepartmental jurisdictional disputes ensue.¹⁷

¹⁶ Assembly of First Nations. Federal Government Funding to First Nations: The Facts, the Myths, and the Way Forward. www.afn.ca/cmslib/general/Federal-Government-Funding-to-First-Nations.pdf

¹⁷ Log onto www.fncaringsociety.com to find out more and demonstrate support for implementing the Joint Declaration of Support for Jordan's Principle.

4. Supports for Children with FASD

There is an increasing awareness of the prevalence of FASD (Fetal Alcohol Spectrum Disorder) in First Nation communities, along with clearer recommendations on how best to meet the needs of school-aged children with FASD or alcohol-related neuro-developmental disorder. Research has reported incidence rates as high as 16% in some First Nation communities, and nearly 50% of children with FASD are placed in care of child welfare because their families do not have the resources or capacity to meet their special needs without supports.

Children with FASD encounter learning difficulties in school, and often demonstrate behavioural abnormalities as a result of an inability to respond to social clues, poor communication, hyperactivity, attention deficit and a lack of organizational skills. Children experiencing these difficulties are at risk for secondary consequences such as coming into contact with the justice system. A high percentage of youth within the criminal justice system have been identified with FASD.

Literature on FASD, however, is full of reports of successes related to early intervention for children in their early to middle childhood years.¹⁸ Intervention by community-based experts working directly with parents and foster-parents to develop communication and coping skills have been demonstrated to benefit both the child and their families. However, funding for supports often depends upon a formal diagnosis of FASD. Waiting lists for First Nation children are long and a definitive diagnosis is often missed before the 'window' for early intervention closes.¹⁹

Recommendation:

If behavioural abnormalities and/or learning difficulties consistent with FASD are identified, culturally based intervention should begin without delay. Even before a definitive diagnosis made, families and children challenged with FASD should have access to appropriate supports and those who serve them should be given adequate training and an opportunity to develop community based supports. Moreover, parents with FASD should be provided with meaningful opportunities to support them in their parenting role.

¹⁸ Fantastic Antone Succeeds. Kleifeld J, Westcott S, eds. Fairbanks: University of Alaska Press, 1993.

¹⁹ Streissguth AP, Barr HM, Kogan J, Bookstein FL. Understanding the occurrence of secondary disabilities in clients with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects. Final report. Seattle: Fetal Alcohol and drug Unit, 1996.

5. Reducing the risk of Type 2 Diabetes in Aboriginal Children

Diabetes occurs in First Nation adult populations at a rate two or three times that in non-First Nation populations. Among First Nation adults with diabetes, 78.2% have type 2 diabetes. Although type 2 diabetes was once considered an adult-onset disease, there has been a steady increase in its occurrence amongst First Nation children. The average age for diagnosis of diabetes in youth is 11 years. Inuit and Métis children are also experiencing much higher rates of type 2 diabetes. Common long-term effects of diabetes have been reported to include activity limitations, loss of feeling in hands and feet, vision problems, circulation problems, poorer kidney function, and heart problems.

Type 2 diabetes is often linked to being overweight or obese, which in many Aboriginal communities results from chronic malnutrition.²⁰ There is a direct correlation between poverty and a poor diet. The Millennium Development Goals include making progress towards increasing the quantity and quality of global food supplies and improving the nutritional status of at risk populations. In Canada, access to sufficient supplies of a variety of safe, good-quality foods by Aboriginal peoples is a serious problem, even where food supplies are adequate at the national level. Many Aboriginal families do not have access to fresh, healthier food choices as a direct result of poverty. There is also a lack of physical recreational activities available to Aboriginal children, either as a result of cost to participate in such activities or because they simply do not exist in many communities.

Recommendation:

Culturally relevant community-run diabetes prevention programs that recognize causal factors contributing to the increased incidences of type 2 diabetes for Aboriginal children should be established in Aboriginal communities, with each being designed to meet the unique needs of each community and run by the community.

²⁰ Malnutrition, as cited in the Millennium Development Goals key findings on nutrition, is frequently part of a vicious cycle that includes poverty and disease. These three factors are interlinked in such a way that each contributes to the presence and permanence of the others. Malnutrition is synonymous with protein-energy malnutrition, which signifies an imbalance between the supply of protein and energy. This imbalance includes both inadequate and excessive energy intake, the latter resulting in overweight and obesity.

List of Key Resources:

Assembly of First Nations. *Federal Government Funding to First Nations: The Facts, the Myths, and the Way Forward*. www.afn.ca/cmslib/general/Federal-Government-Funding-to-First-Nations.pdf

Blackstock, Clarke, Cullen, D'Hondt, Formsma (2003) *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

Canadian Incidence Study of Reported Child Abuse and Neglect: Final Report, (2005).

First Nations Child and Family Caring Society of Canada, Annual Report 2004/05

First Nations Child and Family Caring Society of Canada, *Wen:de: The Journey Continues* (2005).

First Nations Child and Family Caring Society of Canada, *Wen:de: We are Coming to the Light of Day* (2005).

First Nations Child and Family Caring Society of Canada and Pauktutit Inuit Women Association of Canada, *FASD Training Study: Final Report* (2005)

Many Hands, One Dream: New Perspectives on the Health of First Nations, Inuit and Métis children. www.manyhandsonedream.ca.

Nadjiwan & Blackstock (2003) *Caring across the boundaries: Promoting access to the voluntary sector resources for First Nations children and families report*. Ottawa: First Nations Child and Family Caring Society of Canada

National Association of Friendship Centres (October, 2005). *The Impact of Aboriginal Friendship Centres Program on Increasing Canada's Productivity*, Brief to the Standing Committee on Finance.

Paediatrics and Child Health: Journal of the Canadian Paediatric Society (2005), vol.10.

United Nations, *Millennium Development Goals*, www.un.org/millenniumgoals.