



Consensus Statement:

Eight Tenets for Enacting the Truth and Reconciliation Commission's Call to Action #33

The Truth and Reconciliation Commission (TRC) of Canada released 94 Calls to Action on June 2, 2015 including Call to Action #33, which focuses on Fetal Alcohol Spectrum Disorder (FASD). In May 2017, a *Dialogue to Action on the Prevention of FASD* was held in Vancouver, British Columbia on the Unceded Territories of the Coast Salish Peoples including the the xwməθkwəyəm (Musqueam), Skwxwú7mesh (Squamish), Stó:lō and Səlilwətaʔ/Selilwitulh (Tsleil-Waututh) Nations. The *Dialogue* was organized around TRC Call to Action #33, which states:

"We call upon the federal, provincial, and territorial governments to recognize as a high priority the need to address and prevent Fetal Alcohol Spectrum Disorder (FASD), and to develop, in collaboration with Aboriginal people, FASD preventive programs that can be delivered in a culturally appropriate manner."

Co-organized by the Centre of Excellence for Women's Health, the Thunderbird Partnership Foundation, and the Canada FASD Research Network, the event brought together 23 experts from across Canada working in areas of FASD, Indigenous¹ health and wellness. Participants included frontline workers, community leaders, policy makers, and researchers. Tenets reflect the perspectives of the participants and are grounded in research.

Participants developed the following Consensus Statement. The Consensus Statement is informed by the Principles of Reconciliation as outlined by the TRC² which includes: a recognition about the right to self-determination, the role of healing relative to recognition of past harms, the ongoing impact and legacy of colonialism, the need for collaboration and dialogue, and the political will and commitment to bring about paradigm shifts and systemic change. The purpose of this Consensus Statement is to:

- **Inform:** robust and culturally-safer approaches to implementing TRC Call to Action #33 thereby delivering better supports and services to mothers, families and communities.
- **Affirm:** a cross-disciplinary and cross-organizational approach with a priority for Indigenous knowledge to implementing TRC Call #33 while also sharing perspectives and insights with agencies, individuals and stakeholders committed to this same goal.
- **Promote:** an ongoing and collaborative commitment to reconciliation.

Eight Tenets for Enacting Call to Action #33

1. Centering Prevention around Indigenous Knowledge and Wellness

A balance of the body, mind, spirit, and emotion are integral to Indigenous health and wellness. FASD prevention efforts should use a wellness model to support individuals, families, and communities and be guided by frameworks such as *First Nations Mental Wellness Continuum Framework* and *Honouring our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada*. In responding to Call to Action #33, it is essential to center prevention and future research around the wellness framework and the principles of land, lineage, and language. Efforts to re-center Indigenous knowledge supports self-determination – giving individuals hope, a sense of belonging, and a greater understanding of the meaning of life, grounded in a sense of purpose to their life, integral to Indigenous wellness³.

2. Using a Social and Structural Determinants of Health Lens

Prevention and research that is informed by the social and structural determinants of health can provide a foundation to positively support women and their families' healing and wellness. Prevention and research programs that adopt a determinants of health lens address more than individual behaviour through engaging with

¹ Referring to Inuit, First Nations and Métis peoples.

² http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Principles_2015_05_31_web_o.pdf

³ <http://thunderbirdpf.org/nnapf-document-library/>



structural causes including the ongoing impacts of residential schools and structural inequality that continue to impact Indigenous peoples. Engaging with the social and structural determinants of health re-centers conversations about alcohol and other substance use around wellness, removing stigma and blame from the individual and integrating the spirit⁴ to better assist mothers, families, and communities.

3. Highlighting Relationships

The breakdown of family and community relationships was a significant result of the residential school system and subsequent assimilatory policies. These policies separated children from their parents, extended families, and cultures, denying children with parenting knowledge and skills that were crucial to child rearing. Prevention efforts must support parents and extended family; these efforts must also acknowledge the role that the extended family and Indigenous culture has in child development and socialization. This culture-based prevention can further improve the continuity of relationships within families and the community as it places land, lineage, and Indigenous language as central to healing through creating emotional connections and integrating culture into practice. These prevention strategies can also improve relationships between researchers/practitioners and the community through supporting Indigenous worldviews of child rearing.

4. Community Based, Community Driven

Research and prevention need to be community based, driven by and based on community needs. Having community based care allows for care to respond to the needs of the community, ensuring Indigenous concepts of health and healing are central to service provision and support. This goes beyond culturally-safer care, to be grounded in Indigenous health and wellness. Community-based and driven services optimize the capacity to respond to the needs and realities of communities from within the inherent strengths of the linguistic culture of the people. Communities with historical relationships may also collaborate on a nation-to-nation basis, while acknowledging the diversity across nations and First Nations, Métis and Inuit populations in Canada.

5. Provision of Wraparound Support and Holistic Services

Wraparound support coordinates professional and community supports/services to meet the physical, emotional, mental, and spiritual needs of women and families with complex needs. Through using wraparound supports, including the natural supports that exist through culture and extended family, prevention efforts can be tailored to build upon women's and community strengths, and center holistic care around the mother and child, their needs and culture. Integrating wraparound supports in FASD prevention can increase self-determination for women with complex needs, and prevent further trauma, while intersecting determinants of health, to move beyond the narrow focus on individual behaviours towards meaningful outcomes for family and community.

6. Adopting a Life Course Approach

For FASD prevention, adopting a life course approach can support the creation of service delivery standards that engage culturally defined developmental stages of life and celebrate the life cycle. Re-centering service delivery around Indigenous ways of knowing and healing can better connect individuals to their life purpose as its informed by their cultural identity. Moreover, it can help identify support systems for individuals and families that promote positive parenting, help build relationships, and engage with culture to ultimately disrupt trauma arising from structural violence, colonization, and dislocation.

7. Models Supporting Resiliency for Women, Families, and Communities

Models supporting resiliency of Indigenous peoples, including the use of a strengths-based model that champions Indigenous culture as a foundation, are integral to women and their families' wellness and self-determination. Strengths-based models avoid defining one's identity by the label of FASD and avoid stigmatizing language such as the claims that it is "100 percent preventable." Strengths-based models seek empowering action and avoid the

⁴ Honoring Our Strengths: A Renewed Framework To Address Substance Use Issues. Principles: spirit centered. 2011



use of deficit models of disease, punitive approaches, justification for incarceration, and do not promote stigma and social isolation. In FASD prevention programs, models supporting resiliency and strengths-based approaches support mothers and their families, a woman's right to mother, maternal-child attachment, and positive parenting. They encourage families to see their own strengths and the resources they have and will support them, engendering hope, belonging, a sense of meaning, and purpose.

8. Ensuring Long-Term Sustainable Funding and Research

Current services and research priorities do not adequately recognize Indigenous worldviews or knowledge systems. There is a need to address structural and systemic change through decolonizing research and methods as well as applying decolonizing language, and creating dedicated funding and commitments from the Federal Government. This requires universities and granting institutions to prioritize research led by Indigenous peoples and for Indigenous peoples, and using Indigenous worldviews. To be ethical, funders need to ensure that Indigenous-led prevention programs and research are well-funded and sustained to affect change. This is critical to decolonizing research and increasing the quality of life of Indigenous peoples.

The Canada FASD Research Network and the Centre of Excellence for Women's Health look forward to working with the Thunderbird Partnership Foundation and other Indigenous organizations to share these tenets broadly as we develop and study programming on prevention of FASD.



The **Canada Fetal Alcohol Spectrum Disorder Research Network (CanFASD)** is a collaborative, interdisciplinary research network, with collaborators, researchers and partners across the nation. CanFASD has a focus on ensuring that research knowledge is translated to community and policy action.



CanFASD's Prevention Network Action Team (pNAT) is led by researchers at the **Centre of Excellence for Women's Health**. Understanding and acting on the factors that reduce women's risks for developing substance use problems and having a child with FASD requires collaborative action among women, service providers, policy makers, researchers, and the birth mothers and communities who are affected. Since 2006, CanFASD's pNAT has been bridging the country, involving all these sectors.



For the recent meeting in Vancouver CanFASD and the Centre of Excellence for Women's Health were honoured to have the leadership and collaboration of the **Thunderbird Partnership Foundation (TPF)**. The Thunderbird Partnership Foundation is committed to working with First Nations and Inuit to further the capacity of communities to address substance use and mental health issues. TPF promotes a holistic approach to healing and wellness that values culture, respect, community, and compassion.

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Resources We Drew Upon

- Advisory Panel for the Review of Federal Support for Fundamental Science. (2017). *Investing in Canada's future: Strengthening the foundations of Canadian research*. Retrieved from [http://www.sciencereview.ca/eic/site/059.nsf/vwapi/ScienceReview_April2017.pdf/\\$file/ScienceReview_April2017.pdf](http://www.sciencereview.ca/eic/site/059.nsf/vwapi/ScienceReview_April2017.pdf/$file/ScienceReview_April2017.pdf)
- Badry, D., & Felske, A. W. (2013). An Examination of the Social Determinants of Health as Factors Related to Health, Healing and Prevention of Fetal Alcohol Spectrum Disorder in a Northern Context—The Brightening Our Home Fires Project, Northwest Territories, Canada. *International journal of circumpolar health*, 72.
- Best Start Resource Centre. (2012). *The sacred journal from preconception to parenting*. Toronto, Ontario: Best Start Resource Centre.
- Cailleaux, M. & Dechief, L. (2007). "I've Found My Voice": Wraparound as a promising strength-based team process for high-risk pregnant and early parenting women. *UCFV Research Review*, 1(2).
- Health Canada (2015). *First Nations Mental Wellness Continuum Framework*. Retrieved from <http://thunderbirdpf.org/nnapf-document-library/>
- Gerlach, A. (2008). "Circle of caring": A First Nations worldview of child rearing. *Canadian Journal of Occupational Therapy*, 75(1), 18 – 25.
- Health Canada. (2011). *Honouring our strengths: A renewed framework to address substance use issues among First Nations people in Canada*. Retrieved from http://www.thunderbirdpf.org/wp-content/uploads/2014/02/Honouring-Our-Strengths-2011_Eng1.pdf
- Health Nexus Santé. (2010). *A child becomes strong: Journeying through each stage of the life cycle*. Retrieved from https://www.beststart.org/resources/hlthy_chld_dev/pdf/CBS_Final_K12A.pdf
- Little Bear, L. (2000). Jagged worldviews colliding. In M. Batiste (Ed.), *Reclaiming Indigenous voice and vision* (pp. 77 – 85), Toronto, Ontario: UTP Distribution.
- McKenzie, H. A., Dell, C. A., Fornssler, B. (2016). Understanding addictions among Indigenous people through social determinants of health frameworks and strengths-based approaches: A review of the research literature from 2013 to 2016. *Current Addiction Reports*. doi: 10.1007/s40429-016-0116-9
- Muir, Y., & Bohr, Y. (2014). Contemporary practice of traditional Aboriginal child rearing: A review. *First Peoples Child & Family Review*, 9(1), 66 – 79.
- National Council of Aboriginal Midwives (NACM). (2017). *Stories and teachings about infant care*. Retrieved from http://canadianmidwives.org/wp-content/uploads/2017/03/NACM_Booklet_InfantCare_2017_MED.pdf
- National Native Addictions Partnership Foundation Inc. (2015). *Indigenous wellness framework and outcomes*. Retrieved from http://www.addictionresearchchair.ca/wp-content/uploads/2012/04/IWFO_v1.pdf
- Ninomiya, M. E. M., & Pollock, N. J. (2017). Reconciling community-based Indigenous research and academic practices: Knowing principles is not always enough. *Social Science & Medicine*, 172, 28-36.
- Reading, C.L. & Wien, F. (2009). *Health Inequalities and Social Determinants of Aboriginal Peoples' Health*. Prince George, BC: National Collaborating Centre for Aboriginal Health.
- Restoule, B. M., Hopkins, C., Robinson, J. & Wiebe, P. K. (2015). First Nations mental wellness: Mobilizing change through partnership and collaboration. *Canadian Journal of Community Mental Health*, 34(4), 89 – 109. doi: 10.7870/cjcmh-2015-014
- Rowan, M., Poole, N., Shea, B., Gone, J. P., Myota, D., Farag, M., . . . Dell, C. (2014). Cultural interventions to treat addictions in Indigenous populations: Findings from a scoping study. *Substance Abuse Treatment, Prevention, and Policy*, 9(34). doi:10.1186/1747-597X-9-34
- Shahram, S. Z. et al. (2017). Understanding the life histories of pregnant-involved young Aboriginal women with substance use experiences in three Canadian cities. *Qualitative Health Research*, 27(2), 249 – 259. doi: 10.1177/1049732316657812
- Schnarch, B. (2004). Ownership, control, access, and possession (OCAP) or self-determination applied to research: A critical analysis of contemporary First Nations research and some options for First Nations communities. *Journal of Aboriginal Health*, 80 – 95.
- Salmon, A., & Clarren, S. K. (2011). Developing effective, culturally appropriate avenues to FASD diagnosis and prevention in northern Canada. *International Journal of Circumpolar Health*, 70(4), 428-433.
- Skye, A. D. (2010). Aboriginal midwifery: A model for change. *Journal for Aboriginal Health*, 28 – 37.
- Stewart, M. (2016). Fictions of Prevention: Fetal Alcohol Spectrum Disorder and Narratives of Responsibility. *North American Dialogue*, 19(1), 55-66.
- Tait, C. (2003). *Fetal alcohol syndrome among Aboriginal people in Canada: Review and analysis of the intergenerational links to residential schools*. Ontario, Ontario: Aboriginal Healing Foundation.
- Tait, C. (2008). Ethical programming: Towards a community-centred approach to mental health and addiction programming in Aboriginal communities. *Pimatisiwin*, 6(1), 29-60.