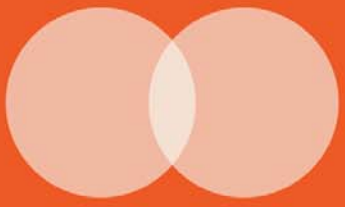
CHALLENGING DRUG PROHIBITION & THE REGULATION OF REPRODUCTION AND MOTHERING

Forum Report 2015



SFU Centre for the Study of Gender, Social Inequities and Mental Health and the Canadian Drug Policy Coalition

Acknowledgments

This report is drawn from a public forum held on May 17, 2014 at Harbour Centre, Simon Fraser University, Vancouver, B.C., Canada. The event received infrastructure and in-kind support from the Centre for the Study of Gender, Social Inequities and Mental Health, and in particular the Centre's Director, Dr. Marina Morrow. I appreciate the Centre's ongoing commitment to creating and sustaining spaces where social, political, and institutional processes can be creatively and collaboratively interrogated, as they relate to health and mental health inequities in policy and practice. I would like to thank the Centre's Criminal Justice System and Mental Health and Addictions Team for their support, both team leaders, Dr. Wendy Chan and Dr. Dorothy Chunn, and members, Dr. Kathleen Kendall and Dr. Robert Menzies. I would also like to thank the Canadian Drug Policy Coalition for their support with social media for this event. This report will also be available on the Canadian Drug Policy Coalition's website (www.drugpolicy.ca).

A number of people also helped out at the forum, in particular Dalia Vukmirovich, who worked as a Research Assistant throughout the project, contributing to the planning and organization of the event and communication with the forum speakers and participants. Without her contributions, the forum would not have been as successful. Dalia also contributed to the formation of this report. I would also like to thank Beth Abbott for editing the final report and Dr. Connie Carter, formerly the Senior Policy Analyst at the Canadian Drug Policy Coalition, for contributing to the forum. Dr. Carter led morning and afternoon question and discussion periods. Finally, I would like to thank Basya Laye who joined us on the day of the forum, helping with the organization of the day's event.

Susan Boyd

University of Victoria
Victoria, B.C.
Canada
scboyd@uvic.ca

Table of Contents

Preface

This report draws from a public forum*, Challenging Drug Prohibition and the Regulation of Reproduction and Mothering,* held on May 17, 2014 at Harbour Centre, Simon Fraser University, Vancouver, B.C., Canada. The public forum and the report were created with the support of the Centre for the Study of Gender, Social Inequities and Mental Health. The forum was intended to create a critical dialogue with some of the leaders in the field about the intersections of drug prohibition, women, addiction, harm reduction, and the regulation of reproduction and mothering. Speakers from Scotland, the United States, and Canada came together at the forum to discuss these important issues. Their expertise and participation at the forum ensured the success of the event and the framework for this report.

The following pages include a short *summary* of each invited speaker's presentation prepared by Susan Boyd and Dalia Vukmirovich from transcripts and notes taken at the forum. Thus, any errors or mistakes in these pages are of our own making and not of the speakers.

Susan Boyd (*PhD, Professor, Faculty of Human and Social Development, University of Victoria, B.C.) is a member of the Canadian Drug Policy Coalition's steering committee and chair of the Policy Working Committee. She also works with local community groups in Vancouver such as the SALOME/NAOMI Association of Patients (SNAP). Her research contributions have been in the areas of women, drug law, policy, and history; maternal/state conflicts; harm reduction; and drug films, media and culture. She is the author of a number of articles and books, including the following: Hooked: Drug War Films in Britain, Canada, and the U.S.; From Witches to Crack Moms: Women, Drug Law, and Policy; Mothers and Illicit Drugs: Transcending the Myths; and co-author of Killer Weed: Marijuana Grow-ops, Media, and Justice; and Raise Shit! Social Action Saving Lives.*

Dalia Vukmirovich *has conducted and contributed to Canadian research around sex trafficking discourse, the sex trade, and law, as well as media representations of issues related to mental health. Dalia completed the MA program in Sociology at SFU, and is a graduate of the SFU BA program in Geography (Environmental Specialty). She balances her work with her other interests, which include photography, film, drawing, dance, and music.*

Introduction by Dr. Susan Boyd

I'd like to take a few minutes to frame the day's event and our interest in highlighting how drug prohibition, women's reproductive rights, and human rights intersect in ways that are harmful to all women, especially pregnant women and mothers suspected of using illegal drugs.

Historian Virginia Berridge argues that nineteenth century opiate use, alcohol consumption, and tobacco smoking were "widely embedded" in social custom in western nations.[1] At that time, anyone could buy without a prescription a wide array of opiate, cocaine, and cannabis based products in the form of tinctures, creams, pills, patient medicines, and powders. Also, at that time concepts of addiction did not exist as they do today. As critical scholars Suzanne Fraser and David Moore point out, "addiction, in *both* its conceptual and material senses, is produced by the times . . . and produced through social and cultural practices" such as print media, film, TV, medical practice, policing, and "the ways we talk about addiction in everyday life."[2] Concepts of drug categories are also produced Categories of good and bad drugs, or legal and illegal drugs, are social, political, and cultural constructions. And criminalized drugs are substances society condemns in a specific historical era. Canadian scholars argue that Canada's first drug laws enacted in the early 1900s were initially — and continue to be — racialized, class based, and gendered. Early on, law enforcement focused on closing opium dens and regulating those associated with the smoking of opium, Chinese residents living in Canada.[3] Moral reformers fuelled fears about white moral women in close proximity to opium-smoking Chinese men, the racialized Other, and fears about women's quick descent into sexual immorality, opiate addiction, and the abandonment of the family. From the enactment of Canada's first Opiate Act in 1908, drug policy quickly centred primarily on law enforcement and prison-sentencing for a growing list of drug offences. The RCMP became both knowledge producers and enforcement agents of newly criminalized drugs.

Following drug prohibition in Canada, no public drug treatment provisions were set up for individuals who used or were addicted to newly criminalized drugs such as heroin or morphine (without a prescription). Nor were drug substitution treatments and drug maintenance programs available for people addicted to narcotics in Canada as they were in Britain. In fact, the RCMP and the Division of Narcotic Control maintained primary control of drug and addiction discourse and policy. Canadian doctors were not allowed to prescribe drugs for maintenance purposes to people identified as addicts. By 1925, the maximum penalty for a doctor issuing a prescription for non-medical use was five years, and the law was strengthened in 1929.

---

[1] Berridge, V. (2013). *Demons: Our changing attitudes to alcohol, tobacco, & drugs*. New York: Oxford University Press.

[2] Fraser, S., & Moore, D. (2011a). Constructing drugs and addiction. In S. Fraser and D. Moore (Eds.), *The drug effect: Health, crime and society* (pp. 1-16). New York: Cambridge University Press, p 7.

[3] Boyd, N. (1984). The origins of Canadian narcotics legislation: The process of criminalization in historical context. *Dalhousie Law Journal*, *8*, 102–136.

Police profiling of people who used heroin and other criminalized drugs led to long prison sentences, whipping, and deportation, especially for those who were poor or working class. Women who used heroin and cocaine were seen as especially immoral and framed as "prostitutes." And it will probably not surprise you to hear that child apprehension was automatic for poor women who used criminalized drugs.

In Canada, law enforcement officials directed drug policy right up until the early 1950s when new psychiatric knowledge emerged, and at which point a group of diverse professionals in Vancouver called for a shift in drug policy from a criminal to a health perspective. However, it took over a decade to establish any public drug treatment for Canadians, and it was not until the 1970s that we saw some movement in the establishment of more services for women. However, drug prohibition and criminal justice as the primary response shaped new services by the medical profession and social work. Punitive drug treatment services and abstinence-based models were dominant, and it was not until the 1990s with the introduction of harm reduction that a larger shift in practice began to take place in Canada. Yet, even with some harm reduction and services for women available, today women who use criminalized drugs continue to suffer more stigma and discrimination than their male counterparts, and in many parts of the country harm reduction services are not available. But let me be clear, we are a drug taking culture, with 3,000 over the counter drugs, and 10,000 prescription drugs to choose from, products that often have the same pharmacological properties as illegal drugs. Our current drug policy, and categories of good and bad drugs, is a little crazy making.

Today we will be hearing about how all women, but more specifically women suspected of using illegal drugs, are socially controlled in ways that differ from men. The social control of women is gender specific. The regulation of women centres on reproduction, mothering, double standards of morality, social and legal subordination, and an ideology that places women in the role of good mother, good wife, and daughter — and when women transgress gender role expectations, they are punished.

Since the 1980s, a wide array of feminist research about women who use illegal drugs has emerged. One study of pregnant women who used illegal drugs in the U.S. notes that "being a woman was a strike against them, being a pregnant woman was a second strike, and being a drug using pregnant woman was the third and final blow in their social standing."[4] However, we know that women suspected of using illegal drugs are not viewed equally, and being poor is another strike against a woman, as is being a racialized or First Nations woman. Women who are suspected of using illegal drugs are vulnerable to interlocking, and often competing, spheres of regulation. Women are regulated by formal drug laws (drug prohibition) and the criminal justice system, through the Indian Act, family law, social service policy, medical policy, and agencies providing services.

In Canada and the U.S., racialized women and poor women have struggled to gain control over their own bodies and their reproduction and to keep the children that they do have. Slavery, residential schools, immigration policy, the eugenics movement (in all its manifestations), forced sterilization, child apprehension, and the medical diagnoses neonatal abstinence syndrome (NAS) and now fetal alcohol spectrum disorder (FASD), have prevented

[4] Sales, P. & Murphy, S. (2000). Surviving violence: Pregnancy and drug use. *Journal of Drug Issues*, *30*(4), 695-724, p. 695.

women from having and keeping their children. Central to the debates are whether these women are fit to parent and whether they are a risk to the unborn fetus. Women are held personally responsible for their pregnancies, birth outcomes, and for the care of their children. Prosecutors and moral reformers frame the issue of maternal drug use as protecting the rights of the fetus versus the rights of women. They also frame women as separate from the fetus and as being adversarial to the fetus. Within this framework, women's rights are in jeopardy.

Canada's current federal drug policy ignores the multiple harms and societal costs that stem from drug prohibition and supports the demonization of people who use criminalized drugs.[5] As a result, abstinence has remained the primary goal of most residential treatment services in Canada, and criminal justice control remains key. Harm reduction services and drug policy reforms are vigorously contested by the Conservative government today.

Although there has been a steady decrease in the crime rate in Canada — for example in 2012 the crime rate was at its lowest since 1972 — the number of drug offences has been increasing since the early 1990s. In fact, from 1998 to 2011 the drug offence rate increased 39.5 percent. In 2012, the police reported 109,455 drug offences. Of the total drug offences, almost 70 percent (69.3) were for possession and 55 percent of the total drug offences were for cannabis possession. Over the last thirty years the number of women charged with a criminal offence has also risen in Canada; so too has the women's prison population. Almost 27 percent of women (compared to almost 16 percent of men) serving time in federal prison were there for drug offences. Although Aboriginal people make up 4.3 percent of the total Canadian population, Aboriginal women make up over 34 percent of all federally incarcerated women in Canada (compared to 21.5 percent of Aboriginal men), an increase of 85.7 percent over the last ten years. And the rates are much higher in provincial prisons. Fifty percent of the total number of women serving time in a B.C provincial prison in 2013 were sentenced for a drug offence (compared to 31 percent of men). Black women in Ontario are also overrepresented, especially in relation to drug offences.[6] Yet, drug use surveys demonstrate that Black women and Aboriginal women do not use illegal drugs more than white women. The overrepresentation of Black and Aboriginal women in our criminal justice system is indicative of systemic institutional racism, systemic barriers, and inequality in women's lives. And here in B.C. and elsewhere, violence against Aboriginal women is systemic.

"In Canada and the U.S., racialized women and poor women have struggled to gain control over their own bodies and their reproduction and to keep the children that they do have." Dr. Susan Boyd

[5] Room, R., & Reuter, P. (2012). How well do international drug conventions protect public health? *Lancet, 379* (9810), 84–91.

[6] Boyd, S. (2015 edition.). *From witches to crack mom: Women, drug law, and policy*. Durham, NC: Carolina Academic Press, pp. 215-217.

Canada's drug laws became even harsher in 2012 as federal mandatory minimum penalties for some drug offences were enacted in March of that year. The diverse people who use illegal drugs have been portrayed by the Conservative Party as "criminals" and "junkies" who threaten families and the social fabric of Canada. This punitive policy does not bode well for women.

For many women, social justice rather than criminal justice is the goal that they are working toward in order to restore control over their own bodies, sexuality, and reproduction, and to eliminate race, class, and gender inequality. Many activists around the world oppose the war on drugs/drug prohibition. They consider criminal justice and military initiatives to be in direct opposition to peace and social justice. They claim that drug prohibition negatively impacts and constrains the policy and practice of health care professionals, social workers, outreach workers, and others, making it difficult and sometimes impossible to provide caring, pragmatic, harm reduction services. Around the world activists and politicians are also revealing how drug wars are linked to global capitalism, western imperialism, domestic and social instability, and growing violence against women and indigenous peoples. The ideologies supporting drug prohibition, stereotypes, and propaganda that claim that specific drugs are bad, that the people who use them are criminal or pathological, that women are immoral and a danger to the fetus and children, that judges are lenient towards drug offenders, and that prison, punishment, and legal and social marginalization are appropriate responses impact vulnerable women. Drug prohibitionist notions also permeate and shape health care, housing, social supports, treatment, popular culture, and our ideas about women and our relations with each other.

One practical response would be to create a legal framework to regulate all currently criminalized drugs, such as the states Colorado and Washington did in relation to cannabis in 2012 (and Oregon and Alaska in 2014). Possibly, if we abandoned drug prohibition, women's bodies would no longer be used as the newest terrain for advancing the war on drugs. Other solutions have to do with social structural change.

At the May 2014 forum, presenters spoke about a range of issues. The first speaker was Dr. Mary Hepburn, both a pioneer and the mother of maternal harm reduction services. In Vancouver and elsewhere we are forever in her debt for inviting us to visit her services in Glasgow and for coming to Vancouver to talk about her work.

* * *

Dr. Mary Hepburn

Dr. Mary Hepburn [BSc MD MRCGP FRCOG] *trained as a general practitioner and then as an obstetrician and gynecologist. Her professional interest is in poverty and health inequalities. Thirty years ago she established and remains medical lead for the Glasgow Women's Reproductive Health Service for women with social problems (now the Glasgow Special Needs in Pregnancy Service). Dr. Hepburn has contributed to research, training, strategic, and service development nationally and internationally. Her groundbreaking reproductive services continue to serve as a model for harm reduction, woman centred care. In honour of her tireless and innovative service, she was awarded The Evening Times Scotswoman of the Year Award in 2014.*

Dr. Mary Hepburn's presentation highlighted the effects of poverty and poverty-related ill health on pregnancy and women's access to health care.

Dr. Hepburn's work started in 1985, several years after she moved to Glasgow. Soon after arriving to the city, Dr. Hepburn noticed a relationship between women who were not accessing antenatal care and issues they were dealing with in their lives, including drug and alcohol abuse, mental health issues, domestic abuse, and violence. Women were not reporting drug or alcohol use. As well, there were no harm reduction policies in place in the services provided to pregnant women at the time that would help ensure appropriate support and care — there was no substitute prescribing or injecting equipment. Instead there were high rates of removal of babies from mothers' care and babies being admitted to the nursery and observed for withdrawals.

"We see women whose babies are sick for all sorts of medical reasons. We see diabetic women on insulin. That affects the baby's health when it's born. Women with mental illness who are on antidepressants, antipsychotics, and the babies are ill when they're born, and we don't prosecute these women for having abused their babies. What we do is make sure to give them good quality, professional care to get the best outcome possible." Dr. Mary Hepburn

When the first community clinic that Dr. Hepburn was involved with was set up in 1985, clinic staff went into the community, letting women know they would work on addressing the issues or concerns that may be preventing them from accessing hospital care, and asking them how they would like to receive care. The clinic was successful, and its services and clientele expanded over the next several years.

The clinic took the approach of meeting women "where they were at." Women were provided care in their own communities. The clinic was also able to adopt harm reduction practices that best reflected women's individual needs. Meeting women "where they are at" also meant recognizing and acknowledging their social realities. For some women this meant stabilizing them on an alternative substance while they were in the hospital, helping them detox, or

recognizing that detoxing was not a viable option for them at the time given their present situations.

Dr. Hepburn said that the work and experiences at the clinic helped to examine and challenge some of the assumptions about pregnancy and addiction. Contrary to assumptions, their experiences showed that it was safe for women to detox — and do so successfully — at any stage of a pregnancy. They were also able to encourage women to breastfeed and in doing so increase the health of their babies. Dr. Hepburn reminded the audience that even though prescribed drugs can also affect babies' health when they are born, pregnant women taking those drugs are not judged in the same way as those taking illegal drugs. At the clinic women who use illegal drugs are provided with good care to help ensure the best possible health outcomes. The clinic took the position that women who were using illicit drugs should be given the same quality, professional care. To women accessing these services, even more important than a high standard of care were non-judgmental, understanding, and compassionate staff.

Despite the care the clinic was able to provide, there were still issues around pregnancy that were not being addressed. These issues were related to poverty, and more specifically to inequality. Dr. Hepburn pointed out that as inequality has been increasing, so have poverty-related ill-health and other adverse outcomes.

She also spoke about other changes she and her colleagues have seen over the years that are shifting how care is being delivered and accessed. Dispersal of disadvantaged communities has meant that needs of those communities are less visible. Funding cuts have led to shifting of the work previously done by clinics to more mainstream health care providers. While this has had some advantages — as some women prefer accessing services at a hospital than a clinic, and hospitals are better equipped to provide a wider range of services — Dr. Hepburn's concern is that more mainstream care might not necessarily be informed by the same sensitivity around issues related to poverty.

In summary, Dr. Hepburn said that one of their achievements is having contributed to the UK maternity strategy the recognition that issues related to poverty and drug and alcohol addiction need to be addressed in pregnancy as part of multidisciplinary obstetric care. She emphasized that poverty is the biggest issue, and that the focus should be on working with people to improve their health outcomes, rather than blaming or taking a moral position against them.

*** * ***

Dr. Ron Abrahams

Dr. Ron Abrahams *is a Family Physician in Vancouver. He is a Clinical Professor in the Department of Family Practice at UBC and Medical Director of Perinatal Addictions at BC Women's Hospital, as well as Consultant Physician at the Sheway Program. He is a member of the Prima National group. Dr. Abrahams is the founding Medical Director of the FIR (Families In Recovery) Rooming-in program at BCWH, the first of its kind in North America. The unit has been named a "leading practice" by the Canadian Council of Health Accreditation, cited by the 2007 Kroeger Award for maintaining a high quality of care, and recently demonstrated peer reviewed improved outcomes. Since its inception 10 years ago, over 1200 women, their babies, and families have benefited from this program. Dr. Abrahams received the 2008 Kaiser Foundation National Award for Excellence in Leadership for Harm Reduction Programs.*

In his presentation, Dr. Ron Abrahams spoke about providing primary trauma-informed care through Sheway and the Fir Square combined care maternity unit at the BC Women's Hospital in Vancouver. Dr. Abrahams pointed out that this work comes from recognizing that women who have experienced trauma in their lives and are dealing with its long-term consequences may subsequently end up using substances to self-medicate or may experience reactions that could be interpreted and addressed in the health system as mental health issues. It also needs to be recognized that social contexts of these women's lives, their substance use, and how they are treated make a difference in the health outcomes for these women and their babies.

> *"Rooming-in is a viable, safe model for providing care for the majority of infants of substance using mothers."*
> *Dr. Ron Abrahams*

When this work was first started, the need to implement a province-wide holistic approach to care that is informed by harm reduction principles was recognized. Dr. Abrahams gave examples of other places in British Columbia that offer similar programs, such as Victoria and Surrey.

Dr. Abrahams spoke about first getting involved in this work over 30 years ago when one of his patients— a street-involved youth — got pregnant. Dr. Abrahams decided to support this young woman through her pregnancy and delivery of her baby. He witnessed her baby being apprehended shortly after the birth and placed into the special care nursery. Dr. Abrahams pointed out that after all this time, he is still in touch with this person, who is now a grandmother. He believes that the support they offered to her played a role in her still being connected to her children.

In the presentation Dr. Abrahams noted that the norm used to be to take children away from mothers who were assumed to be incapable of taking care of them. This approach has

serious negative consequences on the health of mothers and undermines any care provided to these women. This practice was also not based on evidence that would support the claims that this was the proper thing to do; instead it was based on prejudice and judgments made about these women.

Instead, Dr. Abrahams and his colleagues at the BC Women's Hospital decided to focus on the needs of the pregnant women, without placing priority on getting government offices and workers involved. They started with one group of women who were using substances while pregnant. Assigning a nurse to look after these women, they showed that it was safe to keep mothers in the same room and caring for their babies after their deliveries. Dr. Abrahams pointed out that changing ungrounded beliefs, assumptions, and stereotypes depends on individual people who are willing to stand up and do things differently.

There was also recognition that women needed other forms of support after they leave the hospital, such as housing. Dr. Abrahams gave examples of different community-based projects that provide housing support in the Metro Vancouver area for women who are pregnant and those who have delivered in Fir Square.

Dr. Abrahams pointed out that the standard of care has shifted from removing babies from their mothers and putting them into foster care to a focus on supporting mothers.

* * *

Sarah Payne

Sarah Payne *has worked with pregnant substance using women for the past 20 years, initially as a midwife at Sheway, a pregnancy outreach program for substance using women in the DTES of Vancouver and later as Coordinator. Sarah was also instrumental in the opening of Fir Square, a dedicated unit at BC Women's Hospital providing stabilization and detox for pregnant substance using women.*

In her presentation Sarah Payne spoke about the mother/baby program at the provincial prison, Alouette Correctional Centre for Women, in Maple Ridge, B.C. The mother/baby prison program started in 2005. Prior to the opening of the mother/baby program, Sarah Payne was a Fir Square senior practice leader, and some of the mothers who were accessing care at Fir Square were incarcerated. At that time the women would be initiated on methadone at Fir Square because methadone initiation was not being done at the prison. Once stabilized, women would go back to the prison where they were maintained on methadone, and would again come back to Fir to deliver their baby. After the delivery the practice was that the baby would be taken away and the woman would return to prison.

> *"… the purpose of the prison mother/child unit is to allow children to bond with their primary caregiver in a safe and supportive environment and to help mothers develop positive parenting and social skills."*
> *Sarah Payne*

Others working alongside Payne — Fir staff, a prison warden, government social workers — recognized the issues with women being separated from their babies. Out of this recognition they developed a program that aimed to address the gap in services existing between incarcerated women who were pregnant or had just given birth, and those who were able to access a treatment centre that provided services for mothers whose children had to be at least three months old.

This multi-partner program was successful but it ended unexpectedly in 2008 when the B.C. government closed it. It is currently in the process of being reinstated as a result of a B.C. Supreme Court ruling in December 2013. Two women plaintiffs sued the government for violating their constitutional rights and placing them at risk by separating them from their children while they were in prison. The judge recognized that cancelling the program constituted discrimination because it contributed to widening the gap between a disadvantaged group and the rest of the society.

Payne pointed out that people question why incarcerated women are allowed to keep their babies with them if prisons serve the role of punishment. She emphasized the need to keep mindful of who is in prisons — young women of childbearing age, who lack financial resources, and who may come from abusive and traumatic backgrounds. As mothers, they are often their children's primary caregivers. Payne reminded the audience that overrepresented in the Canadian justice system are also indigenous people, who face additional discrimination because of the history of colonization, related intergenerational

trauma and abuse, as well as ongoing racism. Rather than decisions about children of incarcerated indigenous women being made in isolation, indigenous families and communities need to be meaningfully involved in the shared responsibility for the upbringing, teaching, and well-being of their children.

Acknowledging the importance of the bond between an incarcerated woman and her infant is a way of recognizing rights of incarcerated women and their children, as set out by international standards and in international agreements.

Payne noted that keeping babies with their incarcerated mothers has a measured positive impact on both the mothers and the children. Because babies are with their mothers for the majority of time, it leads to better bonded children. Payne noted that having babies in the prison also has a positive impact on other female prisoners as well as the prison staff.

* * *

Lynn Paltrow

Lynn Paltrow, *[Director, National Advocates of Pregnant Women, New York, NY], J.D., is the Founder and Executive Director of National Advocates for Pregnant Women (NAPW). Lynn Paltrow is a graduate of Cornell University and New York University School of Law. As Executive Director of NAPW, Ms. Paltrow combines legal advocacy, public education, grassroots and national organizing, research, and policy work to secure the human and civil rights, health, and welfare of all women, focusing particularly on pregnant and parenting women, and those who are most vulnerable to state control and punishment — low income women, women of colour, and drug-using women. She is a frequent guest lecturer and writer for popular press, law reviews, and peer-reviewed journals. Lynn. Paltrow is also a Gemini and mother of twins.*

Lynn Paltrow's presentation focused on initiatives aimed at controlling pregnant women in the United States, particularly women who are low income, racialized, or who use criminalized drugs. She pointed out a recent example of these interventions related to the increasing focus on drugs and abortion in the U.S.

Paltrow started her presentation with a historical background. Starting in the 1980s and 1990s, there was a focus in the media about concerns over "crack babies," babies born to mothers who were drug users. These stories used false claims and relied on classist and racist narratives to evoke outrage. This resulted in policies that prioritize reporting, surveillance, and punishment. As Paltrow pointed out, there is no evidence to show that these approaches are helpful. In fact, they may stand in the way of women accessing care and support around the time of their pregnancies.

> *"38 states in the United States now have feticide laws that say if you harm a pregnant woman, the person can be charged for separately harming the fetus."*
> *Lynn Paltrow*

Even at the start of her career, Lynn Paltrow was becoming aware of cases of state intervention in the lives of pregnant women. Knowing about these cases led to a project that looked at these cases more closely in order to change some of the related conversations. The project focused on the time frame between 1973 and 2005 and identified 413 cases of forced interventions on pregnant women in 44 states. These cases showed that the law was being used against pregnant women. Pregnancy was used as a reason to arrest, detain, and prosecute women, and to deny them rights explicitly guaranteed in the U.S. constitution. Overwhelmingly, women subject to these interventions have been low income and women of colour. Paltrow pointed out that often babies that are born are perfectly healthy but because they test positive for a criminalized drug, their mothers are still prosecuted. In some cases, these interventions have been results of collaboration among hospitals, police, and prosecutors.

Lynn Paltrow said that most of the cases are happening without authority, since no state has a law that makes women criminally liable for the outcome of their pregnancies. Interventions are instead made possible using feticide laws, which exist in 38 American states. These laws

state that if you harm a pregnant woman, you can be charged separately for harming the fetus. In addition, discussions are currently happening about fertilized eggs, embryos, and fetuses that may expand the reach of these laws. The laws are being passed with the justification that they are a way of reducing violence against pregnant women, despite the lack of evidence showing this to be true. Instead, these are actually attempts to recriminalize abortion laws through saying that fertilized eggs, embryos, and fetuses should be treated as separate from pregnant women.

Lynn Paltrow showed that this is happening at the same time as the war on drugs. She gave the example of the case of Cornelia Whitner, in South Carolina, who gave birth to a healthy baby but was charged under state child endangerment law because she was using an illegal drug while pregnant. As Paltrow pointed out, rather than this being a war on drugs, it is instead a way of controlling women from the time they are carrying a fertilized egg. She gave other examples of women being prosecuted for drinking alcohol or attempting suicide while pregnant, showing how a separate set of laws is being applied to women who are pregnant. A 2006 Alabama law called "chemical endangerment of a child" was meant to punish adults who expose children to dangerous places like methamphetamine labs. It has instead been used against pregnant women — essentially treating their wombs as "dangerous meth labs." Because the meaning of "child" in Alabama state law includes a fertilized egg, this outlaws pregnant women taking any controlled substance, including those that are prescribed. There are connections between these legal decisions and religious beliefs, where biblical passages have been used to argue that protecting the sanctity of all life justifies arrests of mothers where it is deemed necessary.

> *"There is virtually no evidence-based, peer-reviewed research examining the question of what, if any, causal relationship exists between parental drug use and child neglect or abuse."*
> *Lynn Paltrow*

Paltrow argued that part of what constitutes crime in these cases is giving birth, when it concerns certain groups of people. As some of these cases show, decisions about who can parent are being made arbitrarily, such as on the basis of a urine sample. These decisions are being applied in racially discriminatory and targeted ways. Whether someone tests positive says nothing about what kind of a parent they will be. There is no association between drug use and bad parenting. These initiatives are also selective with regard to which harms they take as their focus. There are many other everyday health risks to pregnant women, including environmental risks, mercury levels, lead poisoning, and antibiotics.

Lynn Paltrow ended with a discussion about Tennessee, where conversations were taking place about a feticide law that was meant to apply only to third parties attacking pregnant women. However, prosecutors were also arresting women under this law, and the language of the law was changed so that these arrests were allowed to continue. In April 2014, the Governor of Tennessee signed a state law criminalizing adverse pregnancy outcomes. Thus, pregnant women who use drugs can be arrested.

The passing of the law resulted in a lot of outrage and political organizing. Paltrow pointed out that the governor's support of the law can be looked at in terms of his connections to corporate interests, such as the largest private prison corporation that is based in Tennessee. Also involved in the creation of the law were the Tennessee Medical Association and the Tennessee College of Obstetricians and Gynecologists. They justified their collaboration with state prosecutors and policy-makers by saying that newborns are suffering. However, these claims are not based in reality or existing work that has been done on these issues.

In closing, Lynn Paltrow said that the U.S. needs to remove barriers to treatment, methadone in particular. Women at all stages of pregnancy, from becoming pregnant to labour and delivery, need to retain civil and human rights. She emphasized the importance of listening to women and families. She also spoke about the immorality of profiting from people being sick and by turning patients into criminals, thus making profits from running private prisons. Lastly, she mentioned that issues need to be addressed on a community — and not only an individual —level. Paltrow shared a link to a video about Project Prevention: http://www.youtube.com/watch?v=8sbnDjj7WbU

* * *

Dr. Caroline Tait

Caroline Tait *is an Associate Professor in the Department of Psychiatry, University of Saskatchewan. Dr. Tait received her PhD in medical anthropology from McGill University in 2003 and completed postdoctoral studies in the Division of Social and Transcultural Psychiatry, McGill University in 2004. She is the recipient of individual and interdisciplinary team grants in areas of FASD prevention, women and addictions, ethics, ethics and child welfare, knowledge translation, indigenous mental health and addictions, resiliency, and community-based research. She is Métis from MacDowall, Saskatchewan, Canada.*

Dr. Caroline Tait described the nature of what she does as using different forms of knowledge translation to give voice to people she works with. She started her presentation by giving an example of a documentary film that she worked on. The film was about child welfare, focusing on the question: If the state is the parent, is it a good parent? The film featured a young woman named Chelsea whom Dr. Tait has been in contact with throughout various points in Chelsea's life, including pregnancy and domestic violence.

Dr. Tait spoke about how research became her passion after coming across the "G case," which dealt with a young pregnant First Nations woman in Winnipeg who was sniffing glue.[7] The case ended up in the Supreme Court to decide the issue of whether pregnant women can be mandated into treatment. Dr. Tait and Métis Women of Canada were contacted by Madeline Boscoe from the Canadian Women's Health Network about the case. Dr. Tait sat in on the Supreme Court hearings, where the case focused on fetal rights.

This case raised Canadian awareness about pregnancy and substance abuse. Dr. Tait pointed out that the debate around the issue was interesting to watch. It seemed that women with addictions was an uncomfortable topic of conversation, even among feminists who didn't think women should be mandated into treatment yet had a hard time letting go of the belief that "something should be done."

Dr. Tait pointed out that a difference in the Canadian approach from that in the United States was that in Canada the focus of fetal alcohol syndrome was placed exclusively on indigenous women, rather than on all pregnant women. What sets indigenous people apart from other Canadians are traumatic childhood experiences stemming from the history and the effects of residential schools and the child welfare and prison systems. Dr. Tait posed a question, asking what role government policy plays in indigenous people's lives, how to change this, and how to prevent abusive, traumatic experiences from being repeated over generations. Even current practices in the child welfare system, such as situations where indigenous children can be moved 10, 20, 30, or 40 times, could themselves be seen as abusive.

Dr. Tait pointed out that while things are improving, there are still challenges. A positive change has been that more indigenous people are in school and employed. However, poverty is still a large issue, and the ways in which it can manifest have become more violent and dangerous. Challenges are also being experienced due to major cuts to indigenous

[7] Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.) [1997]

organizations, such as the Aboriginal National Health Organization, as well as the impact of the anti-research position of the federal government. The latter makes it possible to ignore issues that are not being followed through research. In Saskatchewan, the biggest issues are housing and people facing multiple types of illnesses — mental health, addictions, diabetes, and other chronic illnesses.

Dr. Tait also spoke about "intergenerational trauma," which she defined as unresolved trauma happening over multiple generations. There can be both an individual as well as a collective experience of intergenerational trauma — something she mentioned indigenous elders talking about as "blood memory." This trauma experienced at the level of groups and communities can be accompanied by feelings of betrayal, shame, mistrust, guilt, and failure between generations about the abuse that happened, even when there is awareness and understanding of why it happened.

> *"...I often think of women who are struggling with pregnancy and addiction — they really hold a mirror up to our society about what is our society, and how do we treat those in our society who are most vulnerable."*
> *Dr. Caroline Tait*

Racism, negative stereotypes, and narratives about indigenous people and communities persist and inform how issues that they face are understood by the rest of Canadian society. There is a lack of services which stands in the way of addressing some of the issues that can contribute to bad things happening. Instead of recognizing and acknowledging those issues, blame is placed on indigenous people — often through the process of Othering. At the same time there is a tendency to keep invisible and not recognize in the same way indigenous people who are doing well. Dr. Tait pointed out that in cases where individuals are already facing a number of issues, it may not be useful to rely on diagnoses as a way of addressing issues. To an individual already dealing with a number of challenges, a diagnosis can be an additional issue to take on. Dr. Tait pointed out that the impact would not be the same on someone who is middle class and being diagnosed.

Dr. Tait said that pregnancy in women with addictions makes issues visible and pushes other people to face them, whereas otherwise they would remain largely invisible. She spoke about this in the context of holding the rest of society responsible and implicated in social issues, in what has happened to give rise to those issues, and what happens to the mother and her child afterwards. Otherwise, where indigenous women are concerned, issues in Canadian society remain largely unaddressed. Dr. Tait raised the issue of truth and reconciliation, asking how can this take place when only one group is paying attention? In closing, she argued that micro-reconciliations are important — those taking place in everyday interactions between people.

* * *

Marliss Taylor, Tia Smith, and Morgan Chalifoux

Marliss Taylor [RN, BScN, Edmonton, Alberta] *is the Program Manager of the Streetworks Program in Edmonton. She received her Diploma in Nursing in 1982 and Degree in Nursing in 1992. After working for 11 years in adult and pediatric Intensive Care Units in Regina, Edmonton, and San Antonio, she moved to the high Arctic. There she received her certificate in Advanced Practice Nursing and worked as a Nurse Practitioner in the community of Kugluktuk, and Nurse Manager in the community of Gjoa Haven, NU. In 1995 she returned to Edmonton as the Program Manager of the Streetworks program and has worked in Harm Reduction for the past 18 years. She has been involved in Health Promotion/Harm Reduction initiatives in Siberia and Guyana, and a multitude of local, provincial, and national research projects. In 2006 she won the YWCA Woman of Distinction Award in Health and Medicine, and the Nursing Honour Society Community Leadership Award. In 2013 she was awarded the "Clinical Innovation Award," also from the Nursing Honour Society.*

Tia Smith *graduated from the University of Alberta in 2013 with a Bachelor of Science in Nursing. For the past eight months, Tia has been working with the H.E.R. Pregnancy Program within Streetworks as the team's Registered Nurse. The role of the H.E.R. Pregnancy nurse includes involvement in research and evaluation activities, sexual health initiatives, and education of professionals, clients, and the general public. Tia has created a number of information resources for the women who come to the program that are harm reduction based and culturally relevant. She also currently works casually at The Grey Nuns Emergency Department.*

Morgan Chalifoux *has been a pregnancy support worker with the H.E.R. Pregnancy Program at Streetworks for over 2 years, Prior to that time, she had worked at agencies that serve youth and marginalized women. She is a graduate of the Aboriginal Community Support Worker certificate program. Morgan also has a history on the streets that included teen pregnancy, violence, drug use, and gang affiliation, and brings that vast knowledge to her work every day. With the supports from traditional Aboriginal ceremonies and other professionals, she was able to learn how to break the cycle. She is now a parent of three boys and is still actively working on healing. Morgan also has learned through her healing that failure was a part of growth and she channels her experiences to help educate others.*

Marliss Taylor, Tia Smith, and Morgan Chalifoux talked about the Edmonton-based program they run out of Streetworks, a community service agency. Taylor gave background to how the program started. It was developed as a result of a syphilis outbreak, which was especially affecting women working on the streets and Aboriginal women. The program came out of the recognition that women had concerns about health care providers. They were not getting tested because they were not accessing prenatal care due to the fear that their children would be apprehended.

The program was established with the mandate to offer whatever care women would accept. It consisted of two female staff members with shared experiences with pregnancy, addiction, and having been on the streets. The program also included a nurse. Pregnancy support workers were taught some nursing skills to be able to offer care to women who preferred coming to them over accessing care from the nurses. Through the program they offered education, and ended up writing a book with the women they worked with.

> *"We also knew that the women were incredibly concerned with all health care providers, and rightly so. So what we did then — well, the goal that we made was that we were going to try and help the women get as much prenatal care as they would accept, whatever that was." Marliss Taylor*

The program was successful in terms of the number of people it attracted as clients, and the care it provided to the women and their children. In the first year they saw 78 women. That number subsequently grew to 156 in the first two years. Most of the babies were healthy and doing great. For the duration of the program, they had only one fetal death and one underweight baby.

The program ended when its funding was cut, but in 2011 it was replaced by a similar program, called H.E.R. Pregnancy Program and funded by Sacred Communities. This program operated under the same philosophy and the program team offered a broad range of services. They were able to hire three pregnancy support workers, a registered nurse, a social worker, and the existing staff from the previous program. They provided services to women they met through self-referrals and by doing outreach, without following a formal intake process. A lot of the relationships developed with the staff because they had connections to the street themselves in various ways — whether personally, through a relative, friend, or someone they knew. The program works closely with outside partners as well, including a health centre. They will be expanding to other communities such as Calgary and Red Deer.

Marliss Taylor pointed to a number of lessons coming out of the program. They learned the importance of trust and building relationships. They realized that staff with personal experiences similar to the women they are providing services to are most likely to be able to develop trusting relationships because they can relate to and understand what the women are going through. Trust developed between pregnancy support workers and pregnant women helps the latter develop trust in health professionals, as long as they see that their worker trusts them. Morgan Chalifoux also spoke about the importance of relationship-building, which can mean meeting people where they are, including visiting physical spaces to see women rather than making them come to the clinic. Smith gave examples of providing care wherever possible, which includes using non-traditional settings such as her car, or restaurant bathrooms.

The success of the program rested on taking a particular approach in how it was run. The leaders realized that the program needed staff to be women who are broad-thinking and can work in unconventional ways — who can work independently, who understand what is needed, and who do not need a lot of structure in their jobs. Morgan Chalifoux reiterated the

importance of being flexible, open, and non-judgmental. She added that a critical aspect of the program was taking a harm reduction approach, because it builds people up and strives for success. Smith added that they stay women-focused. They recognize that a healthy woman or mom means a healthy baby. Commonly, women with addictions are seen as responsible for endangering their babies' health. The program staff are instead mindful of the fact that women they support might have been victimized and abused themselves, and they tailor their services accordingly. Tia Smith and Morgan Chalifoux spoke about accompanying women to appointments and explaining medical procedures as they are happening. They also remind doctors and nurses to explain to the women what they are doing and why. This is particularly important for women who have experienced abuse and trauma as it lets them know what is happening during processes of medical procedures.

"Harm reduction philosophy and practice builds people up and strives for success. Rather than the usual model of shaming, dismissing and punishing pregnant women who use drugs, relationship-building is extremely important." Morgan Chalifoux

Marliss Taylor pointed out that in Canada a fetus does not have legal rights until the moment of birth. Thus, a fetus cannot be apprehended; only a child can be apprehended by social services following birth. Through their program, they encourage mothers to access children's services early on, rather than having children's services contact them at birth. They work with the children's services unit — located in the same building as their office — that is rooted in harm reduction. The program has built a relationship with the children's services unit and connects them with the women before the baby is born to see what the woman needs, as well as what other needs there may be in her support network. A woman's support may include her partner, baby's father, or another person. The program staff recognize the importance of supporting not just the woman individually but also supporting her within her wider community. Taylor mentioned that connecting women to children's services early has been very important. Chalifoux spoke about the strong relationship that exists between the children's services worker and the women, which enables women to be honest with their worker.

"... we focus on the women because we know if we have a healthy woman, we're going to have a healthy mom, we're going to have a healthier baby as well." Tia Smith

Women they work with make the choices for themselves, and the program staff empower them to do so. Taylor noted that the team supports mothers through various situations, walking along with women through their processes. Smith talked about how their outreach includes talking to women about birth control and making sure they have access to it. The program also supports women who may decide to terminate their pregnancy or decide to place their baby for adoption. In other cases, they help women connect with the processes of their pregnancies. Smith pointed to the importance of pregnancy to some of the women, and particularly the hope that it gives them. Morgan

Chalifoux explained that services offered include a lot of empowerment opportunities, showing women they are capable of parenting and that being a mother is possible for them.

An extensive evaluation of their program pointed out that women who would not normally connect with anybody during their pregnancy connected to their program on average 83 times and up to 167 times. The program connects to women in various ways, including outside, inside, by phone, online, and as part of their needle exchange. Their work includes a lot of nursing services, as well as advocacy, health, social assistance and child services, and legal and housing support. Taylor said that 53 percent of women are parenting, when children's services thinks 95–100 percent would have otherwise lost their children. Some women access care fairly late in the pregnancy so the program staff are sometimes working within a short time frame to stabilize them.

Tia Smith reminded us that post-delivery time is difficult for women who are dealing with other issues, such as homelessness, being on income assistance, or lacking support from their families. So even when their program is supposed to end, they continue to provide support to women for a while after the delivery. Taylor later added that post-partum depression among the mothers is very high.

Morgan Chalifoux pointed out that a number of issues in the system needed to be changed with respect to services and support for the women's basic needs, such as housing. Issues also exist with decisions made about which women are suspected and get tested for substance use. This is often based on assumptions differentiated by class. In addition, when service providers do not take a harm reduction approach in these situations, they can make decisions about a woman's pregnancy that ends up being harmful to both her and her baby.

* * *

Dr. Lenora Marcellus

Lenora Marcellus, PhD *is an Assistant Professor in the School of Nursing at the University of Victoria. She has spent many years working as a nurse in different areas of maternal-infant care and has a long-standing interest in the issue of perinatal substance use and neonatal withdrawal. Lenora has been involved with developing the HerWay Home program in Victoria. She is a member of the Canada FASD Prevention Research Action team.*

Dr. Marcellus started her presentation by talking about the importance of harm reduction in the context of her work with child welfare, foster care, and neo-natal intensive care units. Her work around issues of substance use and pregnancy started around 1999, after reading Dr. Susan Boyd's book which questioned some of the practices that were a part of Dr. Marcellus' work at the time. She pointed out that nowadays there are a lot of resources through which one can learn about harm reduction, but this was not often the case in the past. These resources are also not always part of formal nursing training and education. For Dr. Marcellus, looking into some of these issues was a journey of learning.

> *"… some of the biggest harms are the ones we do to [women] as providers in our system on how we provide care or how we don't provide care." Dr. Lenora Marcellus*

Dr. Marcellus asked what possibilities are there to work with others, bringing together expertise without necessarily critiquing what is already being done? She gave an example of working with Dr. Ron Abrahams and a group in the United States, Vermont Oxford Network. It is a collaborative initiative that addresses a clinical issue every year and works on quality improvement. Currently they are looking at substance use in pregnancy, including how to create more compassion and support for women. As part of their working and learning process, this group looked to Vancouver as an example of innovative and well-done practices. Dr. Marcellus pointed out that while groups in Vancouver may have been doing this work for a long time, for others these are new practices that they can learn from. It is an example of the importance of sharing knowledge and resources.

In Victoria, where this work has been going on since 1996, it took a few years to establish a program in the community, build connections, and get support from existing programs. Working as part of a pregnancy outreach program, Dr. Marcellus had heard stories of women being treated poorly and not wanting to access services. She knew about other programs, like Fir Square, and reached out to her network to develop a program that would similarly follow the principles of harm reduction. Dr. Marcellus emphasized that collaboration is key, as is placing the women and their needs first. She highlighted the importance of Children's Health Foundation of Vancouver Island and the support they provided not only to the children, but also their mothers. She also pointed out that "harm" in the context of "harm reduction" can be experienced in the care that is and is not provided. In this way individual interactions become important ways of practicing "micro harm reduction."

* * *

Dr. Carrie Bourassa

Carrie Bourassa, PhD *is a Professor of Indigenous Health Studies at the First Nations University of Canada and the Special Advisor to the President, Research. Dr. Bourassa is proud to be the successful Nominated Principal Investigator on a Canada Foundation for Innovation Grant that funded the Indigenous Community-based Health Research Labs at FNUniv. Carrie is a public member of the Royal College of Physicians and Surgeons Council. Carrie's research interests include the impacts of colonization on the health of First Nations and Métis people; creating culturally safe care in health service delivery; indigenous community-based health research methodology; indigenous HIV/AIDS research; indigenous end of life care; and indigenous women's health. Carrie is Métis, belonging to the Regina Riel Métis Council #34.*

Multiple Oppressions of Indigenous Women: Deconstructing Colonial Notions of Identity (Summary of Dr. Carrie Bourassa's PowerPoint presentation)

Identities of Aboriginal people have historically been shaped and continue to be shaped by colonial and neo-colonial policy. The term "Aboriginal" is defined in the Canadian Constitution and it includes Canada's "Indian, Inuit and Métis people." There is a great diversity that exists among Aboriginal people. However, attempts at assimilation have had significant negative impact on all Aboriginal people, especially on women.

> *"The attempted assimilation (cultural genocide) of Aboriginal peoples continues to impact all Aboriginal people today but women in particular."*
> *Dr. Carrie Bourassa*

Between 1876 and 1985, a person's "Indian status" was determined by the Indian Act, and it followed the male line. This meant that an indigenous woman marrying a non-indigenous man lost her "Indian status," while non-indigenous women marrying indigenous men gained status. Between 1876 and 1960, indigenous women who lost their status were also not considered Canadian citizens. The Indian Act was revised in 1985, in recognition that it conflicted with the *Charter of Rights and Freedoms*. This however did not address all existing issues. While official assimilation policy was abolished, many identify it as having continued into present.

Aboriginal women experience disproportionate amounts of violence compared to other Canadian women. This includes significantly higher rates of mortality (three times that of non-Aboriginal women), higher rates of violent death (among status Aboriginal women between ages of 25 and 44), and higher rates of injury among spousal violence victims. Aboriginal women also experience higher rates of violence, spousal assault, and emotional abuse. A 2011 Status of Women report identified stigmatization and normalization of violence in Aboriginal communities as important issues. It also brought up a need to address root causes of violence, including colonization and residential schools, as well as to implement culturally-appropriate responses that are holistic and community-based. Impacts of colonization and residential schools have negative effects on women's sense of personal empowerment, and are linked to increased rates of alcohol and substance abuse, and the undermining of family

systems. There are also challenges with women's ability to address abuse — difficulties with disclosing information to formal and informal supports, as well as lack of culturally-appropriate services — especially in northern and remote communities.

Aboriginal women also experience other issues related to health and well-being. This includes rates of diabetes higher than non-indigenous women and indigenous men, and higher rates of suicide, poverty, and obesity among on-reserve indigenous people than off-reserve indigenous people. Indigenous women have lower income rates, less formal education, poorer housing, and are more likely to become single parents. Although indigenous women experience higher rates of HIV infections and AIDS than non-indigenous women, there is a lack of gender- and culturally-specific resources available to them. The main mode of HIV transmission among indigenous women is injection drug use, followed by heterosexual contact (including with partners who are injection drug users). Of all the provinces in Canada, Saskatchewan has had the highest increase in new HIV cases. Aboriginal women are disproportionately represented in these new cases. The province has also recorded perinatal transmission rates almost five times Canada's average. Indigenous women are also at a higher risk of Hepatitis C infections than non-indigenous women.

Historically, indigenous women have also experienced other forms of violence at the hands of the government, specifically in relation to their pregnancies and their children. In Alberta between 1928 and 1972, 2800 women whom government deemed to be "unfit" as mothers were sterilized (both as optional and compulsory procedures) under the *Alberta Sexual Sterilization Act*. Of these, 25 percent were First Nations and Métis, even though First Nations make up only 2.5 percent of Alberta's population. A similar program existed in British Columbia, which started in 1933. In the 1960s, the Canadian government made changes to the Indian Act which mandated social workers to legally remove Aboriginal children from their families and place them into the homes and communities of European-Canadians and internationally through the process of adoption.

Dr. Bourassa speaks to the need to challenge "legislated identity," and the need to reclaim traditional principles and bring them into daily lives. She outlines several different processes of reclamation. Citing Kim Anderson[8], this would include protecting, celebrating, and practicing indigenous teachings; creating spaces for women to work with one another with an aim to benefit their families and communities; creating spaces for men to address and deconstruct colonialism; developing new ways of resisting, reclaiming, (re)constructing in daily lives; resisting oppression; reclaiming indigenous traditions and culture and incorporating these into modern lives; and acting on new responsibilities arising from these processes. Dr. Bourassa herself adds to this list the importance of re-creating new narratives. As well, she shares Elder Betty McKenna's process of reclaiming identities, through "7 stones teaching," which includes growth, adequacy, love, order, social approval, security, and self-esteem. Dr. Bourassa identifies ceremonies as important as well — both those performed daily (like smudging and prayer) and others, such as those related to the full moon.

* * *

[8] Anderson, K. (2010). Affirmations of an Indigenous feminist. In Suzack,C., et al. (Eds.), *Indigenous women and feminism* (Chapter 5). Vancouver: University of British Columbia Press.

Dr. Carolyn Schellenberg

Carolyn Schellenberg, PhD. *Her research emerges from her nursing and public policy work with women, children, and families. Through her work, Carolyn became troubled by government's role — and her own — in constructing mothers as 'risks.' Carolyn's concerns stimulated her research into intersections between the experiences of mothers, medical knowledge, public policies, and oppressive institutional practices. Carolyn continues to practice as a community nurse and is working on a book proposal based on her doctoral research.*

Carolyn Schellenberg[9] explores how the medical diagnosis of fetal alcohol syndrome (FAS) and fetal alcohol spectrum disorder (FASD) directs attention to Aboriginal women and children in Canada. Similar to the U.S., in Canada, Aboriginal women and their children are "disproportionately the subjects" of FAS and FASD research and the subjects of diagnosis. Schellenberg's 2012 ethnographic research draws on a method of inquiry (institutional ethnography) developed by sociologist Dorothy Smith. Schellenberg examines how the medical diagnosis of FAS and the elastic term, FASD, are constructed. This research, conducted in a drop-in centre on the lower mainland of Vancouver, British Columbia, reveals how an "institutional complex of ruling discourses and practices" in the everyday activities of the centre, coordinate how mothers learn to know that their children have FASD.

[Dr. Schellenberg's] research, conducted in a drop-in centre on the lower mainland of Vancouver, British Columbia, reveals how an 'institutional complex of ruling discourses and practices' in the everyday activities of the centre, coordinate how mothers learn to know that their children have FASD.

Dr. Schellenberg notes that poor women, many of whom are Aboriginal, come to the centre where they can obtain various forms of support for their families, including food vouchers, meals, donations such as clothing, and access to an emergency first-come-first-served daycare. The mothers are also offered opportunities, indeed encouraged, to participate in FASD prevention programs that run weekly over a three-month period. In the FASD prevention program, women learn about children's behaviours through an FASD lens. Through the relationships of trust they develop with caring personnel, they also begin to disclose shame and guilt about their own behaviours, and they gain instruction in the importance of having their children assessed for FASD.

Schellenberg's study reveals how poor women searching for social and economic supports for themselves and their families become willing participants in institutional processes that

[9] This presentation is summarized from Dr. Carolyn Schellenberg's PhD research: Schellenberg, C. (2012). *The Social Organization of Mothers' Work: Managing the Risk and the Responsibility for Fetal Alcohol Spectrum Disorder*. Unpublished dissertation, University of Victoria, B.C. It is also published with permission from a section in S. Boyd's 2015 edition of *From Witches to Crack Moms: Women, drug law, and policy.* Durham, NC: Carolina Academic Press.

actually re-shape their talk, their concerns, their responsibilities, and the kind of help they seek for their children. Whereas a mother may drop by the centre with concerns about the lack of safe and affordable housing and daycare, or problems at school for her child, or difficulty providing nutritional meals for her children due to inadequate social welfare benefits, over time, personnel—along with the mother themselves—learn to understand their concerns through the lens of FASD.

FASD is conventionally understood as a "primary brain-based disability" that is thought to be demonstrated in children's learning and behaviour problems and/or psychological signs of this spectrum disorder. Thus, one mother's initial worries about her child's temper tantrums and behaviour and her own consumption of alcohol during pregnancy are now understood as evidence of FASD. That the child and her/his family may have experienced poverty, poor school environments, domestic violence, or other harmful social and economic conditions—these issues are obscured by this all-encompassing explanatory label. FASD discourses prevalent in media, posters in bars, and at the drop-in centre, heighten women's fears for their children. The mothers interviewed in the study worried that without support their children would fail in school or end up in prison (not unlikely fears given the statistics on education for Aboriginal students and overrepresentation in prison and juvenile detention in Canada). At the centre, the mothers are offered support as they are "taught and learned" about FASD and apply it to their own experiences. Thus, even though the mothers are not coerced into having their infants assessed for FAS and FASD, they come to understand at the centre that through obtaining a diagnosis, they can access better help, including special classroom support for their children.

In addition, while the centre provides access to emergency daycare, Dr. Schellenberg observes how the parent or caretaker must sign a consent form or "daily intake form" each day that the child is dropped off at the daycare. The form is standard in the sense that the parent is consenting to field trips or to emergency medical treatment if needed. What is not standard is that the parent is also giving consent for the "child to be examined by Vancouver Medical Coastal Health Department Staff." However, it is not made apparent on the consent form why medical personnel might examine children in the daycare, or what the consequences or outcomes of this type of medical surveillance of children deemed to be "at risk" may actually be. Dr. Schellenberg "notes that in the taken-for-granted practices that she observed in the centre, "informed consent" is breached and relations of power are rendered invisible."[10] The women who come to the centre are poor and Aboriginal, and their "status" "may account for the unusual practices at work in this daycare."[11] Schellenberg suggests that because the daycare "operates as a 'back door' for poor women to access services, it also offers access to professionals who can slip in by the back door to conduct observational work and examinations that may not be tolerated or even deemed to be necessary [or ethical] in other social sites."[12]

Dr. Carolyn Schellenberg's research recognizes that many children, mothers, and families have complex and troubled lives. However, Dr. Schellenberg takes issue with which experiences are discursively constructed as 'problems' and how the women and children

[10] Schellenberg, 2012: 201.
[11] Ibid.: 202.
[12] Ibid.

named in the FASD construction are held accountable and responsible for many social ills that arise from historical and ongoing societal and public policy neglect.

* * *

Tracey Morrison and Dr. Jade Boyd

Tracey Morrison *is an Ojibwe woman from Morson, Ontario. For more than a decade she has been a community organizer for positive change in the Downtown Eastside of Vancouver. She is actively involved in campaigns for social housing, social justice for Aboriginal people, increased welfare rates, and an end to discrimination, marginalization, and colonialism. Tracey is currently the President of WAHRS (Western Aboriginal Harm Reduction Society) and an active member of VANDU (Vancouver Area Network of Drug Users).*

Jade Boyd, PhD *is a Research Associate with the Urban Health Research Initiative, British Columbia Centre for Excellence in HIV/AIDS, and an instructor in the Department of Sociology, University of British Columbia. Her research and teaching interests include: visual media, performance, urban space, moral regulation, and identity. Her research has been published in Gender, Place and Culture* and *Contemporary Justice Review; one of her most recent articles, "Performing East Van: Spatial Control and Class Anxieties" is in Contemporary Ethnography.*

Tracey Morrison reminded the audience that people often define others by the addictions they struggle with. Rather than seeing them as "addicts," Morrison pointed out that addicts are people first, just like anyone else. The project she is involved with aims to show what the women living in the Vancouver Downtown Eastside are like. She gave her own example of being a micro business owner who sells bannock, in part to make money for her addiction.

Tracey Morrison spoke about her involvement with VANDU, Vancouver Area Network of Drug Users. The group was formed in 1998 to bring together people who use drugs with the purpose of helping them improve their lives, families, and communities. VANDU aims to increase capacity of people who use drugs by affirming and strengthening them to reduce harm to themselves and their communities. It also supports communities by organizing local, regional, and national harm reduction education and intervention initiatives.

> *"We organize in our communities to save lives by promoting local, regional, and national harm reduction education and intervention."*
> *Tracey Morrison*

Tracey Morrison is also the president of WAHRS, Western Aboriginal Harm Reduction Society, formed in 2002. She first started being involved as a member, then as vice president, and became president last year. This has been challenging for her as an Aboriginal woman, and a drug user, and she has had a lot of hardships with it, including those resulting from the fact that the majority of members are men. The organization does outreach to attract more women and in partnership with VANDU they also advocate for Aboriginal social issues.

Dr. Jade Boyd further elaborated on the community-based research project mentioned by Morrison. The project included working with women who were involved in leadership roles in

the community, and looked specifically at various kinds of activism and political participation. The project lasted for four months and its various stages developed through discussions among the group members. The group first brainstormed to see what issues were important and how to use the group's creative skills as a way of exploring topics like leadership and activism. The next stage included focus groups in which participants discussed issues they wanted to concentrate on. The project also consisted of community mapping activities and a community walk which included taking photographs. Additionally, each woman had a camera to document images important to her which connected to the "women in leadership roles" theme. These images were explored further through creative writing exercises. The group ended up making collages, and doing a PowerPoint presentation at VANDU. Dr. Boyd highlighted some of the findings coming out of the project and showed photographs taken during the process. Some of the issues the group explored were the barriers and benefits to movement and well-being in the city, political and community engagement, and opportunities for grounded support as offered by VANDU.

"... no one in our group nor the researchers were naïve about the multiple [...] structural barriers and personal factors that negatively shaped their daily lives, but despite that, this particular creative project attempted to highlight the very diverse and extensive activism that women in leadership roles at VANDU occupy."
Dr. Jade Boyd

Tracey Morrison explained how working as part of the project gave women an opportunity to reflect on how much work they do in the course of their days, and the fact that they lead full and active lives which help to empower their community. Morrison spoke about some of the work she is involved with, which includes initiatives that aim to change policies, address social housing, promote harm reduction, and establish an Aboriginal healing and wellness centre. She mentioned how at first she was fairly quiet at community meetings, but with time she has become a lot more vocal. Morrison spoke about being an alcoholic and a drug user and living in poor housing conditions. After a near-death experience, she moved from living in Single Room Occupancy to social housing where living conditions are a lot better. Morrison also spoke about the importance of her community, where she feels safe and which she considers her family. She mentioned that through being involved with the project she is trying to focus on the positives of the community and thereby transform some of its challenges.

Dr. Jade Boyd concluded their presentation by pointing out that the group and the researchers recognized and acknowledged both the structural barriers and personal challenges that shape women's daily lives. However, through this project they wanted to highlight the diversity of activism of women involved in leadership roles at VANDU. By doing so, they hoped to disrupt some of the dominant discourses related to women in the Downtown Eastside who use criminalized drugs.

* * *

Dr. Sydney Weaver

Sydney Weaver, PhD *has taught at University of British Columbia and Vancouver Community College; she has also worked for BC Women's Hospital. She has worked with illicit-drug-using mothers and fathers in child welfare and addictions services for over 15 years. Her research includes: "Left him in the dust: Father exclusion from maternal harm reduction services (2013); Challenges for drug-using mothers with children in kinship care (2011); Healing ourselves: Mothers' recovery from grief and loss (2010); and Shame reduction: Best practice with substance-using mothers (2003). She also conducted an analysis of Nanaimo's drug strategy: 'A secure place in a real community': Illicit drug users in the small city (2011). She lives and works in Vancouver, B.C. and is an active ally for marginalized drug users and indigenous peoples.*

Dr. Sydney Weaver's presentation highlighted her study conducted in Vancouver, Canada, with former patients of a harm reduction maternity ward serving pregnant women who use illicit drugs in Vancouver's Downtown Eastside. The purpose of this study was to generate theory, based on how fathers and mothers were affected by father exclusion, which could inform development of more effective services for substance-using parents. The study demonstrated how father exclusion from services offered at a harm reduction hospital maternity unit affected fathers and mothers struggling with problematic drug use. A qualitative approach, constructivist grounded theory, was used. A purposeful sampling method was employed to recruit 20 parents, 10 mothers and 10 fathers, for one-hour, individual interviews and a focus group. Data was analyzed using AtlasTi (qualitative data analysis software).

Women's addictions treatment in North America perpetuates oppressive structural conditions for mothers.

Women's addictions treatment in North America perpetuates oppressive structural conditions for mothers. A consistent focus on gender obfuscates other structural factors such as poverty, racism, and colonization. Locating both cause of and solutions to problematic substance use individually rather than socially constituted produces a false sense of agency, named "empowerment," in mothers; in reality the oppressive structures that compromise mothers' agency remain uncontested by the treatment industry and therefore by participating mothers. This obfuscating paradigm works to not only subdue mothers' agency, but to perpetuate dislocation, as mothers come to identify family and community members, rather than structural factors, as causal in respect to their problematic substance use. This results in mothers' increased isolation, rather than healing with and within family and community resources.

Representations of substance-using fathers in family and addictions literature are equally problematic and reflect a negative bias. Very little research has been conducted with substance-using fathers. As a result, the few services that do exist for these fathers are misguided and ineffective. Further, the propensity of this group to engage in interpersonal violence may be overestimated; alarmingly, those fathers who do perpetrate violence are

under-served by ineffective models. Not meeting fathers' needs results in increased risk for fathers, mothers, and children.

Use of a grounded theory method highlighted how structural conditions of addictions services recursively interacted with experiences of fathers and mothers, amplifying obstacles experienced by parents using illicit drugs, such as poverty, stigma, racism, and homelessness. Fathers' gender-based exclusion compounded feelings of exclusion based on race and class, and negatively affected mothers.

Representations of substance-using fathers in family and addictions literature are equally problematic and reflect a negative bias.

Central themes of the study included: Fathers' identity and location; Fathers' relationships; Dimensions of father exclusion (food; space; family); and Routes to belonging. Of particular importance is the theme 'Fathers' relationships.' This category reflected fathers' expression of their need for relationships and ways these needs were unmet within social contexts. 'Father's identity and location' captured fathers' substantive self-reflection and voicing of values. These findings in particular challenge common representations of fathers in the addictions literature.

Themes emerging from mothers' data included: Services for mothers: Being a good mother; Relationships with fathers: Best friends/tired of trying to help; and Mothers on fathers' exclusion: Nobody's going to help me raise this kid. These themes captured mothers' intense frustration and concerns about father exclusion, and describe the isolation and burden they experience as a result of father exclusion.

The findings of this study contest the tenets of 'difference' feminist theory that underpin contemporary addictions services for women, demonstrate the importance of including fathers in antenatal, natal, and postnatal addictions services, and contribute to theory aimed at disrupting and destabilizing gender norms.

* * *

Appendix: Support

Below are three organizations that advocate for the human and reproductive rights of women and an end to drug prohibition:

Canadian Drug Policy Coalition

http://www.drugpolicy.ca

Abortion Rights Coalition of Canada

http://www.arcc-cdac.ca/home.html

National Advocates for Pregnant Women

http://www.advocatesforpregnantwomen.org/