

**Aboriginal Women With Addictions: A Discussion Paper on
Triple Marginalization in the Health Care System**

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EXECUTIVE SUMMARY

This discussion paper is the product of a practicum placement at the Northern Secretariat of the BC Centre of Excellence for Women's Health. To fulfill the requirements of a bachelor degree in Social Work, UNBC student Lynda Brunen chose to learn about the research process.

Under the supervision of Northern Secretariat Coordinator Dr. Theresa Healy, Lynda undertook to: 1) define and develop a viable research question in women's health, 2) identify and assess some relevant literature, and 3) provide recommendations for further research. In this paper she synthesizes available material to explore racism in health care. In particular she examines the ways in which First Nations women who misuse substances are triply marginalized in the health care system, and the devastating implications of this.

As a result, this paper delineates a significant, poorly understood and under researched problem in health care delivery. Lynda's ground work provides a basis from which to launch further research with potentially significant outcomes.

Lynda has recently been hired to help develop the first youth detox centre in British Columbia, here in Prince George. This work, demands not only the practical skills of a social worker, but also the analytical skills of a researcher.

1. INTRODUCTION

A middle aged Aboriginal woman staggers into the emergency room. She appears disoriented and confused. The smell of alcohol lingers in the air as she approaches the nurses' station. It is apparent that she has hurt her hand, which is poorly bandaged with a dirty, bloody rag. The on-duty nurse takes a full-body look at the woman and says brusquely , "Have a seat, we'll be right with you."

Aboriginal¹ women with substance misuse issues face a number of barriers when seeking access to the mainstream health care system. Not only do they face societal stigmatization due to their addictions, but also the issue of racism is clearly apparent. Stereotypes such as 'the typical drunken Indian' or 'the uneducated Indian welfare case' are woven into the very fabric of our society.

What is it that makes Aboriginal women different from non-Aboriginal women when it comes to accessing health care? Are there indeed actual barriers that exist? Is it perhaps the Aboriginal woman's own perception of self, or low self-esteem that is the barrier, and not the health care system? These are only a few of the many questions that arise while exploring the issue of racism and women's health.

¹ For the purpose of this paper, the terms Aboriginal and First Nations are used interchangeably.

2. JUSTIFICATION AND OBJECTIVES

As a student, interested in these questions, I had to look at my own experiences in the health services field and determined that this issue was something that I knew very little about. Additionally, an initial search of literature determined that there is little direct material relating to the ways in which racism and substance misuse interact for Aboriginal women trying to access mainstream health care. Consequently, in this report, I try to answer some of these questions for three reasons.

The first reason personal and it is related to my direct experiences as an Aboriginal woman. I had always felt an underlying tone of dismissal when accessing the health care system. It seemed as though there was an assumption that I could not possibly know my body enough to understand if anything was wrong. I felt belittled, degraded, and misunderstood enough times to almost convince me that I was not "good enough" to access health care. As a result, because I felt this treatment was racially motivated, I was unable to find a physician whom I could trust for medical help.

The second reason for exploring this topic stems from my experiences as a health care worker, working with high-risk, street-involved, substance addicted people. There are many stories that people have discussed with me in regard to their treatment in the health care system. Most of these clients were Aboriginal people. They too felt that mistreatment within the health care system was racially

motivated. Because many were drug addicted, they felt an added dimension to the interaction that was beyond my own experience. I believe that it is through their stories that we might uncover, explain and work to solve the problems of discriminatory and racist behaviour in the health care system.

Finally, this research will begin to fill an important gap identified in other recent work dealing with Aboriginal women in the health care system. For instance, it complements a study recently conducted by Browne, Fiske, and Thomas (2000). Their work documented the racist and systemic barriers that Aboriginal women in a northern BC community must face when they attempt to access the mainstream health care system. Within that study, the mistreatment of women who misuse substances was documented, but a detailed exploration was beyond the scope of the research. Consequently, I hope to build on this work in which qualitative analysis of people's direct experiences led to valuable insights, public awareness and recommendations for policy.

In this paper, I present and discuss the findings of a preliminary literature review. The immediate objective for this paper is to delineate the topic and its research potential. The longer term goal is to develop a research project that addresses the questions raised here.

3. REVIEW OF THE LITERATURE

A literature review was conducted using journal articles, books, and Internet resources. It should not be considered an exhaustive inventory of sources due to time constraints, and limited availability of material in the north. The circumstances of Aboriginal women who misuse substances are located at the intersection of three important themes: First Nations people's experience with accessing the health care system, issues surrounding health and substance misuse, and issues particular to First Nations women. Before undertaking primary research to examine the effects of their interaction, these themes must be understood independently.

3.1 FIRST NATION'S HEALTH CARE

Quality of access and care for Aboriginal health has been shown to be ineffective. Shestowsky (1995), suggests five barriers to access that Aboriginals face in urban centers:

1. Lack of information or availability of and access to health care services
2. Lack of health care services and programs
3. Limited access to traditional healing services
4. Negative and stereotypical attitudes on the part of health care providers
5. Absence of translation services for Aboriginal languages

There is also a distinction between the urban Aboriginal and the Aboriginal who continues to live on a reserve. Each of the five barriers pointed out by Shestowsky (1995) are amplified for those living on reserve land. Many reserves do not have accessible roadways, requiring portable health services to be transported to remote locations. Although, services may be provided weekly or bi-weekly, health care is still considered inadequate. As stated by Frideres (1991), "...basic health issues of Indians are related to socio-economic issues" (p 271). Services tend to be lacking essentially because the maintenance of health is linked to socio-economic factors. Socio-economic status of the Aboriginal population has historically been ignored by the Canadian health system.

Browne, Fiske, and Thomas (1999) suggest that "...it was generally assumed that Aboriginal people would soon be so fully assimilated into mainstream society, that to devote a branch of health and resources specifically to them was an unnecessary extravagance" (p 5). Even when the "unnecessary extravagance" was provided, it did little to address the real issues that undermine the health and well being of Canada's First Nations people: the multiple social effects of assimilation and racism, land appropriation and the systemic destruction of families, to name a few. It is difficult to say then that the health care system is appropriate, accessible, and sufficient for Aboriginal people living on or off reserve.

Another confounding factor that emerged in the literature is that Aboriginal people who are able to access health services may use those services in a manner to which Euro-Canadians are not accustomed. For instance, Waldram (1994) contends that "Aboriginal people utilize the health care system differently, and 'problematically', because they are culturally 'different'" (p 323). Points to consider in this case are the mannerisms, attitudes, non-verbal communication, and style of dress and deportment of Aboriginal peoples compared to non-Aboriginals. For example, an Aboriginal person who lives on a reserve may not share the dominant fashion sense or be perfectly groomed just for a visit to the doctor's office. Euro-Canadian values about appearance and the culturally constructed norm of making a "good first impression" are therefore implicitly violated by the Aboriginal person who may not make judgements by appearance.

Language barriers such as accents and use of words can also pose problems. These can often be interpreted as demonstrating lack of intelligence rather than regional and cultural diversity. Non-verbal communication poses another problem. For many Aboriginal people for instance, a traditional demonstration of respect, trustworthiness and honesty is *minimal* eye contact. By contrast, dominant societal norms have turned *maximum* eye contact into a sign of caring, honesty and taking things seriously. Misinterpreting the cultural norms of many Aboriginal people can lead to implicitly discriminatory practices in the health care encounter.

As described at the outset, it is no secret that stereotypes exist in the health care system. However, *where* they exist, *how* they are demonstrated, *who* is imposing ethnocentric values and *what* are their implications are common points of debate. Carroll (1993), suggests that “it is likely that the attitudes of health care workers are very important in determining standards of care delivery...” (p 710).

Unfortunately, it is seldom positive attitudes that are manifested in the delivery of health services to First Nations people. Rather, the negative, prejudicial, and stereotyped attitudes at work in the larger society, tend to be brought sharply into focus within the health care system. In their recent study of stereotypes toward Aboriginal people, Claxton-Olfield and Keefe (1999) suggest that “the three most frequently mentioned characteristics of Native Indians were alcoholic, lazy and uneducated” (p 2). If these are the most frequently mentioned characteristics of Aboriginal people in general, it is not difficult to see how the same assumptions are perpetuated within the health care system.

3.2 SUBSTANCE MISUSE

Setting the ‘race card’ aside for the moment, the second factor leading to stigmatization is the theme of substance misuse. This was also a relevant theme in the literature. According to Carroll (1993) “Situations of uncertainty, such as dealing with drug users are likely to provoke strong emotional responses” (p 705). Professionals in the health care field find that “this client group is generally regarded as demanding” (Carroll, 1993, p 705). Another point that Carroll raises

is that “Drug misusers tend to lead chaotic lifestyles and to be indifferent to their health” (p 706), implying the difficulties faced by providers who work with them.

Considering the dominant medical model of addictions and substance misuse, some literature suggests that Aboriginal people and non-Aboriginal may people view the condition differently. For instance, Frideres (1994) states that “the use of certain substances are not defined as contributing to illness within the First Nations community. Smoking, drinking and the use of certain other drugs are not normally considered causing certain illnesses” (p 286). However, the medical model or disease model of addictions is the primary measure used in the mainstream health system. This model attributes health and social problems to the use of substances.

By contrast, from the perspective of many Aboriginal people, addictions are looked upon as the compound result of the assimilation process that Aboriginal people have undergone. It is considered a symptom of the many underlying political and socio-economic misuses that are inter-connected within Aboriginal life. Thus many Aboriginal people consider substance misuse an *escape from* life's problems and not as a *cause of* them. Frideres (1994) summarizes this point: “...we have only looked at the *symptoms* (substance misuse) of these diseases and have not tried to address the *causes*” (p 284). The result, according to Frideres, is that "an acceptance of fate is the preferred response" (p 286).

Conceding in this manner becomes another barrier to accessing the health care system.

3.3 FIRST NATIONS WOMEN

I have often heard it said that, 'It's one thing to be an Indian, but it's another to be an Indian woman'. Combine this factor with that of substance misuse and the result is a severely marginalized sub-group of our society. Just as ethnic differences have long been a popular reason for discrimination, so too has gender. Causes of marginalization faced by Aboriginal people in general are multiplied by the issues that are distinct for Aboriginal women. Cassidy, Lord, & Mandell, (1995) contend that "Aboriginal women must deal with discrimination based on gender, class, and race" (p 39). This is unlike women of the dominant white culture who may face gender and class issues, but rarely must challenge racial discrimination.

With respect to access to the health care system, Cassidy, Lord, & Mandell (1995) suggest that "...white, middle-class women's experience is taken as the norm" (p 32). The 'norm' in this case is not inclusive or understanding of cultural differences and circumstances that add to ethnic diversity. Burnette (1996) discusses a study conducted by Sanders-Phillips (1996) stating that "...ethnic minority women have little trust in the health-care system and often believe they will encounter racism if they seek treatment" (p 1). Burnette (1996) also goes on

to say that, “These perceptions also decrease the chances that the women will comply with a medical regimen, whether it’s visiting with a psychologist, taking prescribed medications, or avoiding drugs and alcohol” (p 1). A health system built on ‘white’ experiences, combined with the negative societal perceptions of substance misusers and the already systemic gender biases, are a potent mix that creates an ultimate barrier for substance abusing Aboriginal women attempting to access the health care system.

4. DISCUSSION

4.1 OVERALL PROBLEM

Women who cannot access adequate and appropriate medical services or who are poorly treated in the health care system may ultimately end up in far a worse condition than where they started. The lack of care, sensitivity, and understanding can result in a devastating snowball effect in families, communities and society as a whole. The implications of racism towards these women certainly extend further than the micro (individual) level. For instance, in families where substance abusing women cannot access help, the results can often be manifested in disorders such as Fetal Alcohol Syndrome / Effect, child misuse domestic violence, suicide and poverty and further social isolation.

Communities feel the effects in a different way. Loss of language, loss of culture, loss of families, and loss of the sense of community leaves behind a grief stricken path for all to walk. The implications in First Nations communities are the continued result of devastating attempts to assimilate as well as lack of adequate health services. In non-Aboriginal communities, stereotypes, prejudices, and discrimination continue to perpetuate systemic barriers.

Overall, the dominant society absorbs the devastating effects by implicitly continuing to oppress. The results are inevitable. Bishop states that "...unhealed pain is like a gully carved in our thinking. Each time we see a situation that looks anything like the one that hurt us, we do not stop to think creatively, we simply react with whatever behavior might protect us, whatever behavior protected us in the past".

For the Aboriginal woman who misuses substances, her behaviour is a protective mechanism learned through years of pain. This type of protection, however, is part of a vicious cycle that serves to perpetuate discriminatory actions and thus more pain. Too many Aboriginal women tolerate their emotional and physical pain for as long as they can by masking it through drug and alcohol use. In return society continues to punish them and keep them in their victimized state.

4.2 POTENTIAL SOLUTIONS: WHAT RESEARCH CAN DO

Any changes to health policy or procedure that are to be meaningful in lives of First Nations women who misuse substances must directly address the realities they face. This can only be accomplished when the women's concerns are listened to and their context is completely understood. One way to do this is through appropriate and relevant research that focuses on the concerns expressed by the women themselves. Therefore, what follows are suggestions for an integrated research agenda to address the health of First Nations women who misuse substances.

Recommendations:

- Participatory research must be undertaken so that First Nations women may have an invested ownership of research and potential solutions.
- The research should be action-oriented so that it not only identifies issues, but immediately starts to implement solutions. Conducting collaborative research itself is considered one solution because it develops valuable skills and awareness for participant-researchers.
- The research must be women-centered. Community-based research is not enough because women's voices are often drowned out in First Nations communities by high profile, political issues such as land claims

negotiations for example. Issues like these may be beneficial for the community as a whole, but they rarely promote change for the individuals.

- The historical perspective must also be considered in the research. Many First Nations communities were once matrilocal and matrilineal. Patriarchy has been an overpowering force in eliminating the matriarchal voice in these communities. Respect has been displaced and domination and degradation have taken its place. Thus, many women are controlled today by a newly evolved state of 'traditional governance' that has adopted the dominant patriarchy. Traditions that once held women in high esteem have been surpassed. The negative repercussions are continually manifested in the health of Aboriginal women today.

We cannot undo history, but we can commit to creating a brighter future by recognizing -- through appropriate and effective research -- what works and what does not. Information can effectively be gathered through in-depth interviews, participant-observation etc. in front-line health agencies. Data from programs such as detoxification units, needle exchanges and drop-in medical clinics can be qualitatively analyzed to explore the experiences of First Nations women. This data can also be compared with their experiences in other health services such as health clinics, hospitals, and emergency units that do not normally focus on

addictions. From my experiences and observations, these programs vary drastically in their level of care, service delivery, and understanding of ethnic diversity. Future research can further develop these findings.

5. CONCLUDING REMARKS: WHAT I HAVE LEARNED FROM THIS RESEARCH

In this discussion paper, I have used personal experience, observation and a preliminary review of the literature to uncover some of the hidden and implicit factors that contribute to the construction of barriers in health care services for Aboriginal or First Nations women who misuse substances. First, the health care system perpetuates the inherent values, beliefs, and attitudes of mainstream society. These values and associated actions can be implicitly discriminatory in nature and are founded on historical fallacies. They perpetuate a vicious cycle for First Nations women who misuse substances. Stigmatization toward substance users deepens the wounds of the Canadian Aboriginal population who are often already oppressed by poverty, lack of adequate housing and insufficient health care services. A final barrier is the continued devaluing of women as a whole. In a society that professes to provide equality for all, women -- and especially Aboriginal women -- remain at the 'bottom of the totem pole' so to speak.

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