

**EARLY INTERVENTION FOR INDIGENOUS FAMILIES AND CHILDREN IN
BRITISH COLUMBIA: A CRITICAL INQUIRY**

by

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Abstract

Improving the health of Indigenous children and fostering health equity requires a radical shift beyond prevailing health care approaches. Early child development (ECD) and intervention programs are increasingly recognized for their potential in promoting children's health and well-being, and appear to be ideally positioned to play a vital role in fostering child health equity. Currently, there is a lack of research on early intervention (EI) programs in the context of Indigenous families and children in Canada.

The purpose of this qualitative study was to generate knowledge on *how* an urban-based EI home-visiting program for Indigenous families and children in BC, known as the Aboriginal Infant Development Program (AIDP), influences families and children's health and well-being, and is responsive to health and social inequities affecting families and children experiencing social disadvantages. This inquiry was informed by critical theoretical perspectives and undertaken in collaboration with the AIDP. Ethnographic methods of data collection were used to obtain the perspectives of: Indigenous caregivers (n=10) and Elders involved in AIDPs (n=4), AIDP workers (n=18), and administrative leaders of organizations that hosted AIDPs (n=3).

Findings demonstrate: (a) a relational perspective of ECD that emphasizes how family well-being and children's health equity are inextricably connected, and shaped by intersecting structural inequities; (b) how AIDP workers influence family well-being and foster child health equity by: (i) contextually tailoring their programs for female-led single-parent families in urban contexts, and (ii) reframing the EI process so that it is responsive to women's agency and self-identified priorities, which are frequently centered on accessing determinants of health and navigating the health care and child welfare systems; (c) how locating AIDPs in multi-service organizational hubs enhances a relational orientation to EI, and (d) how AIDP workers traverse a contested ECD landscape and an increasingly complex relationship with the child welfare system. This knowledge will be used to inform and enhance AIDP practices, policies, and education. These findings are applicable to a broad range of ECD and health care disciplines, including occupational therapists, and EI programs that serve Indigenous and non-Indigenous children who live with social disadvantages that stem from structural inequities.

Preface

This dissertation is original, unpublished, intellectual work by the author, A. J. Gerlach. The Behavioural Research Ethics Board (BREB) at the University of British Columbia (UBC) approved the research design and implementation reported in Chapter Four. The BREB certificate number was: H13-01373.

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List of Abbreviations

AIDP	Aboriginal Infant Development Program
AHS	Aboriginal Head Start
ASCDP	Aboriginal Supported Child Development Program
ASQ	Ages and Stages Questionnaire
BC	British Columbia
CRC	Convention on the Rights of the Child
CRP	Community research partner
ECD	Early child development
EI	Early intervention
EIT	Early intervention therapy
FC	Friendship Centre
FNHA	First Nations Health Authority
IDP	Infant development program
IPV	Intimate partner violence
KTE	Knowledge translation and exchange
MCFD	Ministry of Children and Family Development
RCAP	Royal Commission on Indigenous Peoples
SIRF	Service Indicator Reporting Framework
TVIC	Trauma and violence informed care
UBC	University of British Columbia
UK	United Kingdom

UN	United Nations
US	United States
WHO	World Health Organization

Glossary

Aboriginal	The term ‘Aboriginal’ is inclusive of First Nations, Inuit and Métis peoples in Canada regardless of where they reside or whether their names appear on an official register. It is also the term that is currently used in BC to distinguish early childhood programs specifically for Indigenous communities, families and children. For example, Aboriginal Head Start and Aboriginal Infant Development programs. (Please see the explanation of the term Indigenous below).
Aboriginal Infant Development Programs	Early intervention home-visiting programs specifically for Indigenous families with infants and young children in diverse on and off reserve community settings in all regions of BC.
Caregiver(s)	The person, or people who provide parenting care to an infant or child on a daily basis. Caregivers can be parents, grandparents, aunts or uncles and other involved adults.
Child neglect	Neglect is defined as a failure to supervise or to adequately meet a child’s physical needs to the point where the child is, or could be, harmed. Neglect includes failing to provide a child with food, shelter, basic health care, supervision, nurturing or protection from risks (Government of British Columbia, n.d.).
Child welfare system	This system provides services mandated under the Child, Family and Community Services Act and delivered by the Ministry of Children and Family Development (MCFD) in BC under its Child Safety, Family Support and Children in Care service line (Representative for Children and Youth, 2013).
Early childhood	A critical period of human development from the prenatal stage to school entry at approximately five years of age.
Early childhood programs	A general and inclusive term for all programs serving families and young children, including: early intervention, preschool, Head Start and child care programs.
Early intervention programs	Home-visiting programs that provide a range of supports to families with young children from the prenatal period, or birth, up to school entry or first year of kindergarten.

Early intervention therapy programs	Programs funded by the MCFD in BC that are typically administered and provided through child development centers. Therapy services typically encompass occupational therapy, speech language pathology, and physiotherapy for children from birth to school age.
Elders	“Elders are those who have shown wisdom and leadership in cultural, spiritual, and historical matters within their communities, and might not necessarily be old. Elders represent an essential connection with the past; they are keepers of the community knowledge and supports of its collective spirit” (King & Gracey, 2009, p. 82).
Food insecurity	“Families and individuals who lack food security: (1) experience uncertainty that they will be able to acquire and consume adequate quality and quantity of food in mainstream ways; (2) consume nutritionally inadequate food; (3) consume reduced quantity and quality of food, and (4) acquire and consume food in non-mainstream (socially unacceptable) ways or by incurring further disadvantage (deplete assets, not spending on necessary medications, etc.)” (Rainville & Brink, 2001, p. 5).
Housing insecurity	High housing costs in proportion to income, poor and unsafe housing conditions, unstable neighborhoods, overcrowding, or homelessness (Wellesley Institute, 2010).
Indigenous peoples	‘Indigenous’ is increasingly becoming the preferred term used by Indigenous scholars and organizations including the Canadian Institute of Health Research (2014) which states that the term ‘Indigenous’: “relates to many peoples’ beliefs that their cultures, histories, and responsibilities are tied to the lands” and denotes “a collective history among Indigenous Peoples of the world regardless of borders” (p. 2). Also as Tuhiwai Smith (2012) states, this term “internationalizes the experiences, the issues, and the struggles of some of the world’s colonized peoples. . . . The term has enabled the collective voice of colonized people to be expressed strategically in the international arena” (p. 7).
Occupational therapy	In Canada, occupational therapy has been defined as “the art and science of enabling engagement in everyday living, through occupation; of enabling people to perform the occupations that foster health and well-being; and of enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life” (Townsend & Polatajko, 2007, p. 2).

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Dedication

'Family' is at the core of this research. I dedicate this dissertation to my family, 'my boys': Eric, Max, Jackson, and Dudley. My ability to devote my time to undertake doctoral work and this research would not have been possible without the encouragement, support, understanding, and 'shoulder to cry on' of my partner in life, Eric - thank you for always being by my side on this journey. For Max and Jackson, thank you for coming up to my office and sitting on my lap despite how much you have grown over the course of my doctoral work! I hope that I have inspired you both with the belief that learning is life-long. For Dudley, thank you for making me walk on the trails with you every morning and for always being under my desk.

CHAPTER 1: INTRODUCTION

1.1 Background to the Study

The entry point for this doctoral research was my experiences and relationships with Elders, families, and colleagues in a rural First Nation community in southwestern British Columbia (BC) that started in 1998 when I was invited and funded by the community to provide occupational therapy for children and youth who had developmental challenges. Over the years my learning about the history of colonization in Canada and how it is implicated in the health and well-being of Indigenous families and children, my positionality as a Euro-Canadian occupational therapist, and the need to transform how occupational therapy is provided in the context of Indigenous families has developed through longstanding relationships with Indigenous families and early childhood colleagues particularly in BC. This research builds on these relationships and the work of early childhood program workers, community and family members, and academic and political leaders who have supported and informed the development of early childhood programs for Indigenous communities, families, and children in Canada and BC since the early 1990s (Assembly of First Nations, 2005; Ball & Pence, 2006; Blackstock, Bruyere, & Moreau, 2006; British Columbia Aboriginal Child Care Society, 2011; British Columbia Assembly of First Nations, First Nations Summit, & Union of BC Indian Chiefs, 2008; First Nations Early Childhood Development Council, 2011; Gray Smith & Gerlach, 2012b; Greenwood, 2005, 2006).

On entering this research, I had several key assumptions that were integral to the underlying premise of this dissertation and informed my choice of theoretical

perspectives and methodology. My pre-existing assumptions were that: (a) the health and well-being of Indigenous children are inseparable from the health and socio-economic prosperity of their families and communities; (b) early intervention (EI) based primarily on a biomedical perspective of early child development (ECD) and health is often ineffective in promoting Indigenous children's health and fostering health equity; (c) responsive EI for this population requires that Indigenous peoples' perspectives, experiences, and knowledges are foundational to program design and delivery, and (d) AIDP workers are already engaged in activities, albeit unknowingly, that address child health equity issues.

This study supports the claim made by Britto and colleagues (2011) that: "fueled by neuroscience, economic data and program evaluation results children's early years are emerging as a public policy focus around the world" (p. 3). In the context of working with marginalized populations, quality early childhood programs can promote long-term health and social outcomes and contribute to family and community well-being (Britto et al., 2011). With this in mind, this study generates new knowledge on *how* a provincial EI home-visiting program, the Aboriginal Infant Development Program (AIDP) of BC, influences the health and well-being of Indigenous families and children in this province, and addresses social and health inequities affecting families and children living with social disadvantages. The purpose of this inquiry is consistent with the World Health Organization's (WHO) Commission on Social Determinants of Health (2011a) recommendation for research on the effectiveness of interventions incorporating an equity perspective in early childhood programs.

1.1.1 Indigenous Children and Health Inequities

In the context of Indigenous children in Canada, health is conceptualized by Blackstock and colleagues (2006) as “a state of being, involving multiple perspectives and dynamic mechanisms that systematically promote well-being” and “where all children are able to reach their potential” (p. 4). Despite this conceptualization, and some improvements in recent years, Indigenous children remain significantly less healthy than other children in Canada on virtually all measures of health and quality of life (Blackstock et al., 2006; Findlay & Janz, 2012; Postl, Cook, & Moffatt, 2010; Representative for Children and Youth & Office of the Provincial Health Officer, 2015; Smylie, 2012). Moreover, Indigenous children continue to be recognized as one of the most vulnerable population groups in Canada (Canadian UNICEF Committee, 2009; National Alliance for Children & Youth, 2011; Representative for Children and Youth & Office of the Provincial Health Officer, 2015). This is of serious concern given that the pervasive and persistent poor health outcomes experienced by many Indigenous infants and young children are a direct result of colonization¹ and social determinants² that are potentially preventable and remediable (Greenwood & de Leeuw, 2012; Greenwood et al., 2015).

¹ For Indigenous peoples in Canada, colonization is considered a determinant of health (Greenwood, de Leeuw, Lindsay, & Reading, 2015; Reading & Wien, 2013). The historical and ongoing effects of colonization on families and children’s lives is discussed in Chapter Two.

² Social determinants are “the conditions in which people are born, grow, live, work, and age – key determinants of health equity. These conditions of daily life are, in turn, influenced by structural drivers: economic arrangements, distribution of power, gender equity, policy frameworks and the values of society” (World Health Organization, 2013b, p. 5).

In the colonial landscape of contemporary Canada, intersecting structural inequities³ continue to create and sustain the economic and social oppression of many Indigenous communities and families (First Nations Information Governance Centre, 2012; Fontaine, 2007). Structural inequities are directly linked to health equity issues. Health equity has been defined by the WHO (2008) as the absence of systematic and remediable differences in one or more characteristics of health across socially, economically, or demographically defined populations or population groups. Health equities are closely connected to the distribution of power and wealth within a society, and the social conditions in which people live (World Health Organization, 2008). The WHO (2013) describes health inequities as “unfair, avoidable and remediable differences in health status between countries and between different groups of people within the same country” (p. 3).

As the WHO (2013a) states: “the early childhood period is the most important developmental phase of life. Experiences during this time determine health, education and economic prospects throughout life” (p. 28). There is increasing evidence that children who experience health and social inequities, from the prenatal period to age five, have an increased risk of poor health outcomes and adverse life experiences across their life course (Bell, Donkin, & Marmot, 2013; Hertzman, Li, Mattes, McMurray, & Stanley, 2009; Shonkoff, 2012; Shonkoff, Boyce, & McEwen, 2009). Marmot (2011), a former

³ Closely aligned with the mechanisms of social injustice, structural inequities refer to policies and practices that are embedded in systems and organizations in our social world, such as welfare, health care, economics, and justice which function to produce an inequitable and unjust distribution of social determinants of health (Browne & Stout, 2012; Farmer, Nizeye, Stulac, & Keshavjee, 2007).

Chair of the WHO Commission on Social Determinants of Health, has called for “equity for every child from the start” as a fundamental aspect of addressing health inequities within and between countries (p. 702). Despite garnering national and international attention from child advocacy groups, the social injustices and health inequities experienced by many Indigenous children in Canada remain largely unaddressed (Anaya, 2014; Canadian UNICEF Committee, 2009; First Nations Child and Family Caring Society of Canada & KAIROS: Canadian Ecumenical Justice Initiatives, 2011; National Alliance for Children & Youth, 2011). Federal and provincial public health strategies to amend these inequities have been met with only limited success (Representative for Children and Youth & Office of the Provincial Health Officer, 2015).

This inquiry supports the evidence that addressing health inequities requires a radical shift beyond traditional health care responses (Baum, 2007; Marmot & Wilkinson, 2006; World Health Organization, 2013a). Emerging health equity research based on adult populations who experience socio-economic marginalization, indicates that addressing health inequities cannot be achieved merely by providing more health care; rather other sectors must contribute to sustaining health and well-being, and must be engaged and actively involved (Browne et al., 2012; Kurtz, Turner, Nyberg, & Moar, 2014; Ndumbe-Eyoh & Moffatt, 2013; Rasanathan, Montesinos, Matheson, Etienne, & Evans, 2011). The direct link between Indigenous children’s poor health and development outcomes and a range of adverse social and Indigenous determinants has been well documented (de Leeuw & Greenwood, 2011; Greenwood & de Leeuw, 2012; Greenwood et al., 2015; Postl et al., 2010; Reading & Wien, 2013). In addition, prevailing early childhood discourses recognize child health equity as vital for achieving

improved population-level health across the lifespan (Bell et al., 2013; Siddiqi, Hertzman, Irwin, & Hertzman, 2011). However there remains a distinct lack of scholarship focused on *how* health inequities affecting Indigenous children are being, or could be, addressed in Canada and internationally.

1.1.2 Indigenous Early Childhood Programs

Providing intervention as early as possible in a child's life is premised on the assumptions that: (a) positive early experiences and environmental influences at this critical developmental stage has the potential to promote healthy development in childhood and across the life course, and (b) some families can benefit from extra support in raising healthy children (Siddiqi et al., 2011). Indigenous early childhood programs⁴ support infants and young children to have the best start in life, as all early childhood programs strive to do. Early childhood programs that are embedded in local Indigenous and community cultures, languages, practices, and histories also play a foundational role in developing children's sense of cultural identity, which is increasingly recognized as an Indigenous determinant of health (Chandler & Lalonde, 1998, 2008; Greenwood & de Leeuw, 2012; Greenwood et al., 2015; Reading & Wien, 2013). In this context, Indigenous early childhood programs are increasingly recognized as critical sites for cultural rejuvenation, language revitalization, and community (re)building (First Nations Early Childhood Development Council, 2011; Greenwood, 2006; Greenwood & Jones, 2015; McIvor, 2005). Conversely, early childhood policies and practices that privilege

⁴ For the purposes of this dissertation, 'Indigenous early childhood programs' refers to all programs that are designed and delivered specifically for Indigenous communities, families, and children. These are discussed in more detail in Chapter Two.

prevailing knowledge, based on Western biomedical universality, may represent a more insidious form of assimilation because Indigenous knowledges tend to be subjugated and silenced (Ball & Le Mar, 2011; Greenwood, 2006; Niles, Byers, & Krueger, 2008; Rodríguez de France, Pence, & Greenwood, 2007).

Scholars and researchers suggest that improving the health of Indigenous children requires a fundamental shift that is responsive to Indigenous communities and families' lived realities and broad, multifaceted socio-economic and historical determinants that can often have a profound impact on health and life opportunities in early childhood and beyond (Greenwood & de Leeuw, 2012; Priest, Mackean, Davis, Waters, & Briggs, 2012b). From this perspective, Indigenous early childhood programs need to adapt to both the historical realities and the current socioeconomic and community contexts of families and children's lives (Greenwood, de Leeuw, & Fraser, 2007). Currently there is a lack of evidence on EI home-visitation programs for Indigenous families and children in Canada.

1.2 A Community Research Partnership: The Aboriginal Infant Development Program of British Columbia

This research builds on my 15-year history of working with, and learning from, Indigenous early childhood programs and organizations in BC, and advocating as an ally for the health and well-being of Indigenous families and children (Gerlach, 2007; Gerlach & Zeidler, 2004; Gray Smith & Gerlach, 2012a). The study was undertaken in

partnership with the Provincial Office and Steering Committee of the AIDP in BC⁵. The AIDP is an EI home-visiting program specifically for Indigenous families with infants and young children, in diverse on and off reserve community settings in all regions of the province. The primary goal of AIDPs is to “promote early childhood development so that children will reach their full potential and children will be physically, emotionally, mentally and spiritually healthy, safe and secure, ready for early and lifelong learning, and become socially engaged and responsible” (Office of the Provincial Advisor for Aboriginal Infant Development Programs, 2013, p. 8). Since the program’s inception in 1992, AIDPs have grown from two to 49 programs, and have steadily evolved away from their mainstream origins as they have taken root in local communities around the province.

My motivation to partner with AIDP for this doctoral research was driven by my desire to collaborate on generating knowledge on how health inequities affecting Indigenous children can be addressed through innovative and responsive forms of EI. Through my work, as an occupational therapist working with several Indigenous communities and organizations in BC, I have continually questioned how my practices can be more effective. While AIDPs, like all early childhood program in BC, do not have an explicit mandate to address child health inequities, anecdotal evidence suggests that AIDP practices are aligned with, and enact elements of, what health care research has identified as ‘an equity-oriented approach’ (Browne et al., 2012). In addition, AIDP leadership has identified the need for research to more explicitly describe and frame,

⁵ AIDPs originated in BC and are currently only provided in this province. An overview of the AIDP is provided in Chapter Two.

from a theoretical perspective, how their programs influence children's health and well-being, and for analyses that can illuminate how AIDPs can be further responsive to the unique strengths and needs of Indigenous families and children in diverse parts of the province.

1.3 Theoretical Framework

Early childhood scholars have called for research that is informed by critical theoretical perspectives in order to generate knowledge that attends to the diversity of children's socio-cultural, historical, and geographical locations and identities (Cannella & Viruru, 2004; Dahlberg, Moss, & Pence, 2006; Woodhead, 2011; Yelland, 2010). As I discuss in Chapter Three, the theoretical framework for this critical inquiry is grounded in relational epistemologies and informed by the perspectives of postcolonial feminism and Indigenous feminism. This theoretical lens, creates space for diverse knowledges and perspectives, and broadens and deepens early childhood discourses.

To the best of my knowledge, this is the first inquiry of its kind that draws on these particular theoretical perspectives in the context of EI with Indigenous families and children. This research fills a gap in the literature by: (a) applying postcolonial feminist and Indigenous feminist analyses to an Indigenous EI home-visitation program, and (b) contributing to the ongoing theorizing on the relevancy of postcolonial feminism and Indigenous feminism to research concerned with promoting social justice and health equity for Indigenous peoples.

1.4 Problem Statement

Consistent with recommendations made in the Royal Commission on Aboriginal Peoples (1996b), and reaffirmed by the Truth and Reconciliation Commission (2015),

many Indigenous communities and leaders are committed to supporting the health and well-being of their children (Blackstock et al., 2006; British Columbia Aboriginal Child Care Society, 2011; First Nations Early Childhood Development Council, 2009; Gerlach, Gray Smith, & Schneider, 2009; Health Council of Canada, 2011). Despite growing concern and criticism from national and international child advocacy groups (Canadian UNICEF Committee, 2009; First Nations Child and Family Caring Society of Canada & KAIROS: Canadian Ecumenical Justice Initiatives, 2011), Indigenous children continue to experience a disproportionate burden of health inequities compared to any other child population in Canada (Blackstock, 2011; de Leeuw, Lindsay, & Greenwood, 2015; Greenwood & de Leeuw, 2012). This is of serious concern given that health inequities in early childhood can influence health, well-being, and life opportunities across the life course (Bell et al., 2013; Lake & Chan, 2014).

The AIDP of BC is a well-established EI home-visiting program for Indigenous families with young children from birth to age six who are living in on and off reserve communities throughout the province. AIDP workers have evolved and adapted their practices over the years in response to the unique strengths and needs of Indigenous families and children, and the diverse socio-geographical contexts in which they live. Given the lack of research on AIDPs, a systematic study of how an EI home-visiting program influences the health of Indigenous families and children in BC, using a health equity lens, may expand our understanding of how these programs may further enhance their practices and programming. In this inquiry the perspectives and experiences of Indigenous caregivers of young children, Elders, AIDP workers, and administrative leaders of organizations that host AIDPs are recognized as legitimate sources of

knowledge, and are considered foundational to fulfilling the research purpose, objectives, and empirical questions guiding this study.

1.5 Research Purpose

The purpose of this dissertation research is to generate knowledge on *how* an EI home-visiting program for Indigenous families and children in BC, known as the AIDP, influences families and children's health and well-being, and is responsive to health and social inequities affecting families and children experiencing social disadvantages. This knowledge is grounded in the perspectives and experiences of Indigenous caregivers and Elders involved with AIDPs, AIDP workers, and administrative leaders of urban-based organizations that host AIDPs in different regions of BC.

1.5.1 Research Questions

This study aimed to answer the following research questions:

- (1)** How do AIDPs influence the health and well-being of Indigenous families and their infants and young children?
- (2)** How do AIDPs address health equity issues affecting Indigenous infants and young children?
 - (a)** How do AIDPs address the effects of socio-economic inequities affecting Indigenous families and children?
 - (b)** How do AIDPs respond to, and how are they shaped by, diverse family, geographical, and organizational contexts?
 - (c)** How do AIDPs respond to, and engage with, Indigenous families including those who may be reluctant to access programs for their children?

(3) What are the implications of the knowledge generated by this inquiry on AIDP practices, education, and policy, and on wider EI practices and policies?

1.6 Research Outcomes and Significance

It is anticipated that the knowledge generated by this study will provide an increased understanding of: (a) how AIDPs provide EI; (b) AIDPs' strengths and vulnerabilities, and (c) how organizational and policy issues influence AIDPs. This knowledge has the potential to benefit Indigenous families and children in BC by strengthening AIDP practices, education, and policy to be more responsive in supporting their well-being and fostering child health equity. A theoretical and evidence-informed understanding of AIDPs may also inform the future development of more relevant and meaningful outcome measures for these programs. It is also anticipated that the knowledge generated by this research will contribute to filling a current gap in the literature on how EI can foster health equity for *all* children living in conditions of social disadvantages that are rooted in structural inequities, in BC and more widely in Canada and beyond.

It is also anticipated that the knowledge generated by this study will inform how early intervention therapy (EIT), including occupational therapy, can be provided in ways that are respectful and responsive to Indigenous families and children's lives. From an occupational science perspective⁶ it is anticipated that this knowledge will provide more

⁶ Occupational science is an academic discipline that emerged in the late 1980s and early 1990s in order to generate a greater understanding of the full scope and nature of human occupation and its relationship and impact on individuals and society as a whole (Forwell, 2008). In Chapter Three I discuss occupational science in relation to my disciplinary orientation to this study.

nuanced understandings of taken-for-granted occupations that are integral to families' everyday lives and well-being.

The significance of this study is clear when one considers the ongoing, pervasive, and socially unjust nature of health inequities that are experienced by Indigenous children who live in one of the wealthiest countries in the world. This research is also aligned with a growing call from Indigenous leaders to honor our national obligations under the Convention on the Rights of the Child (CRC) to ensure that all Indigenous children, regardless of where they live, are able to achieve the same level of health as other children in Canada (Blackstock, 2011, 2013). This study aimed to begin to bridge the current gap in the literature on how to address health inequities that affect a disturbingly high number of Indigenous children, by generating a more systematic and theoretically informed understanding of how an EI home-visitation program influences Indigenous children's health and well-being and addresses social and health inequities affecting Indigenous families and children experiencing social disadvantages.

The knowledge generated from this research has the potential to contribute to a broad range of interdisciplinary programs and professionals that provide early childhood programs for marginalized families and children, including refugees and new immigrants in Canada and internationally. The findings may also be particularly salient for the growing number of EI therapists in BC who are seeking guidance on how to transform their services so that they are responsive to Indigenous families and children's lives (J. Gordon, personal communication, November 15, 2010).

1.7 Organization of the Thesis

Chapter One provides an introduction to this research, including background information on the study, the research purpose, and the intended outcomes and significance of this study. **Chapter Two** presents a synthesis and critical analysis of key literature relevant to this research topic. This chapter also includes a description of AIDPs. **Chapter Three** describes the theoretical perspectives informing this research. This includes a discussion of my positionality, including a critical occupational science perspective that shapes my approach to health and EIT. I also discuss my relational epistemology, and the theoretical perspectives of postcolonial feminism and Indigenous feminism that collectively shape and inform the theoretical framework for this research. **Chapter Four** describes the methodological approaches and methods used in this study, including how they are informed by decolonizing methodologies and shaped by the theoretical perspectives discussed in the previous chapter. **Chapters Five and Six** report on the findings of the research, and integrate perspectives from the literature and theory to help contextualize the findings. **Chapter Seven** provides a discussion of the findings and concluding comments on this dissertation.

CHAPTER 2: SYNTHESIS OF KEY LITERATURE

In this chapter, I provide a synthesis and analysis of key literature relevant to the topic of this study. The chapter has six sections. The **first section** provides an orientation to a critical perspective of social justice and health equity in the context of Indigenous children. The **second section** begins with an overview of Indigenous families in the context of Canada and BC. This is followed by a critical analysis of the literature on how the health and well-being of Indigenous women⁷ and children are influenced by intersecting structural inequities. The **third section** analyzes prevailing perspectives on early childhood, and provides a foregrounding for the **fourth section**, which is a synthesis of a broad range of interdisciplinary literature in relation to EI, including pertinent evidence on how intervention can be more socially responsive. The **fifth section** of this chapter provides an introduction to the Indigenous early childhood program landscape in Canada and BC. This is followed by the **sixth** and final section, a description of AIDPs in BC, as the EI program involved in this study.

2.1 Social Justice and Health Equity in the Context of Indigenous Children

In this dissertation, I situate children's human rights and health equity within a broader critical conceptualization of social justice. Critical perspectives on social justice counter the neoliberal pull of individualism as they "are concerned with the ways that structural and social inequities shape peoples' experiences of health, illness, and health

⁷ As discussed in this dissertation, my focus on women is because: (1) a significant number of Indigenous children live in families headed by single parents, the majority of whom are women (Statistics Canada, 2013); (2) the majority of caregivers who access AIDPs are women, and (3) the majority of caregivers who participated in this study were women.

care” (Browne & Reimer Kirkham, 2014, p. 24). From a critical perspective, health as a human right represents a radical and promising shift in how social justice is conceptualized, as “the object of social justice becomes health outcomes not primarily equal access to healthcare services” (Reimer Kirkham & Browne, 2006, p. 328).

Theorizing from this critical vantage point draws attention to how intersecting historical, political, and socio-economic structures create and sustain social injustices, and locates Indigenous peoples’ health within a broader social discourse of self-determination and human rights (Browne & Reimer Kirkham, 2014; Kuokkanen, 2012). In taking up a critical theoretical stance, social injustices and health inequities are conceptualized as relational, contextual, and intersectional (Reimer Kirkham & Browne, 2006).

Structural inequities and structural violence are key inter-related analytical concepts that are taken up in this dissertation. As Farmer emphasizes: “No honest assessment of the current state of human rights can omit an analysis of structural violence” (Farmer, 2005, p. 50). Closely aligned with social injustice, structural violence⁸ draws attention to how structural inequities within our social institutions, deny human rights, constrain human agency, and prevent particular individuals and population groups from having the resources needed to reach their full potential while sparing others (Farmer et al., 2007; Hanna & Kleinman, 2013). Structural violence is increasingly seen

⁸ The term ‘structural violence’ was first defined by Galtung (1969), a Norwegian sociologist. Structural violence refers to the often taken-for-granted ways in which potentially avoidable systemic exclusion and disadvantage are embedded in our everyday social arrangements and institutional structures, and become embodied as health inequities for particular individuals and population groups (Farmer, Kim, Kleinman, & Basilico, 2013). The insidious and silent nature of structural violence frequently results in it becoming seemingly invisible and accepted as “the way things are” (Farmer et al., 2013, p. 5).

in public and population health as a major determinant of the distribution of health inequities (Cocks, 2012; Farmer et al., 2013; Mukherjee et al., 2011).

Governments have a fundamental role to play in addressing unjust and potentially preventable social structures that result in particular population groups experiencing health inequities (Farmer et al., 2013; World Health Organization, 2013a). A discourse of children's rights as framed in the UN's CRC⁹, has attempted to reconfigure existing power relationships and structures between children and the state by identifying children's health from a social determinants perspective, and as a shared responsibility between parents, the community *and* the state (Tobin, 2006; Vandergrift & Bennett, 2012). 'General Comment 7' of the CRC (2005), to which Canada is a signatory, states that "early childhood is a critical period for realizing children's rights" (p. 3). This includes ensuring:

"that all young children (and those with primary responsibility for their well-being) are guaranteed access to appropriate and effective services, including programs of health, care, and education specifically designed to promote their well-being. Particular attention should be paid to the most vulnerable groups of young children and to those who are at risk of discrimination" (Committee on the Rights of the Child, 2005, p. 11).

The UN Declaration on the Rights of Indigenous Peoples and the CRC affirm the individual and collective rights of Indigenous peoples to decide how they raise, care for, and educate their own children; to be involved in all levels of policy development,

⁹ The Convention on the Rights of the Child (United Nations Committee on the Rights of the Child, 2009) was "the first core human rights treaty to include specific references to indigenous children in a number of provisions. . . . The specific references to indigenous children in the Convention are indicative of the recognition that they require special measures in order to fully enjoy their rights" (p. 2).

decision-making and service provision, and for Indigenous children, without discrimination, to have the highest attainable standard of health, and access to programs that promote their culture and language (Anaya, 2014; Truth and Reconciliation Commission of Canada, 2015; United Nations, 2008; United Nations General Assembly, 1989). Thus, health as a human right recognizes that children's rights to health are interdependent and indivisible from their economic, social, cultural, civil, and political rights (Tobin, 2006; UNICEF, 1999). This approach frames access to social determinants of health as a human right, and aims to hold governments accountable for having the necessary socioeconomic and political structures in place to promote children's health (Vandergrift & Bennett, 2012).

As reported by the Canadian UNICEF committee (2009), the persistent, widespread, and potentially remediable nature of health inequities that are experienced by Indigenous children in Canada, represent possibly the greatest challenge to social justice that this country has ever faced. National and international child advocacy groups have called on the federal government for political action to redress the social injustices and health inequities, framed as human rights violations, that many Indigenous children continue to experience (Blackstock, 2011; British Columbia Aboriginal Child Care Society, 2014a; Canadian Council of Children and Youth Advocates, 2011; Canadian UNICEF Committee, 2009; First Nations Child and Family Caring Society of Canada & KAIROS: Canadian Ecumenical Justice Initiatives, 2011; Truth and Reconciliation Commission of Canada, 2015).

Although the concept of health equity has been in existence for decades (Whitehead, 1991), it has gained traction in recent years in national and international

health research and policy alongside a growing recognition of social determinants of health (National Collaborating Centre for Determinants of Health, 2013; World Health Organization, 2011b, 2013b). Currently, health equity provides an anchor for public health policy in Canada (Public Health Agency of Canada, 2014). However, health equity for children remains on the margins of early childhood research and policies in this country (McNeill, 2010).

2.2 The Context of Indigenous Families and Children's Lives

There are an estimated 1.4 million Indigenous peoples in Canada, who self-identify as First Nations, Métis, and Inuit, and who make up 4.3% of the total population (Statistics Canada, 2013). Across the country, there are more than 600 First Nations and over 60 Indigenous languages (Statistics Canada, 2013). BC is home for approximately one third of the Indigenous peoples in Canada¹⁰ (Statistics Canada, 2013). BC has the greatest diversity of Indigenous cultures in Canada, with 198 First Nations, 11 unique language families, and more than 60% of the country's First Nations languages (Aboriginal Affairs and Northern Development Canada, 2010).

The transmission of Indigenous ways of knowing and being in the world, and sense of cultural identity and continuity, are increasingly recognized as a critical Indigenous determinant of children's health and well-being across their life course, and for the future collective health and well-being of their communities and Nations (Chandler & Lalonde, 1998, 2008; Greenwood et al., 2015; Reading & Wien, 2013).

Indigenous researchers concur that in many communities, Indigenous families, Elders,

¹⁰ According to Statistics Canada (2014), approximately 5% of the total population 'had an Indigenous identity' in BC in 2011.

and increasingly early childhood workers contribute towards an intricate system of knowledge transmission to nurture children's identities, ancestral knowledges and languages, and their relationships to the spirit and natural worlds (Greenwood et al., 2007; Irvine, 2009; McIvor, 2005; Smylie et al., 2009). As Greenwood (2013) writes: "Central to the concept of caring, and to centering children as the purpose of living and life, is a recognition of the sacredness of identity and the responsibility and work involved in passing cultural knowledge across generations" (p. 99).

As Kirmayer and colleagues (2009) highlight, there is "enormous diversity in values, lifestyles, and perspectives" within Indigenous communities and urban populations (p. 6). Indigenous children live in diverse socio-cultural and geographical contexts specific to their families, communities, and Nations. In Canada, the demography of Indigenous families differs significantly from non-Indigenous families, with a fast growing¹¹ and youthful population¹², with larger families and younger parents (First Nations Information Governance Centre, 2012; Statistics Canada, 2013). A significant number of Indigenous children live in single-parent families, the majority of which are led by women¹³ (Statistics Canada, 2013). In BC, the majority of Indigenous families live in urban centers (Statistics Canada, 2008). Evidence suggests, however, that there is a

¹¹ Between 2006 and 2011, the Indigenous population increased by 20% compared with 5% for the non-Indigenous population (Statistics Canada, 2013).

¹² In BC in 2011: The median age of the Indigenous population was 29 years, compared to a median age of 42 years for the general population (Statistics Canada, 2014). In Canada, children 14 years and under accounted for 28% of the Indigenous population compared with 16.5% among the non-Indigenous population (Statistics Canada, 2013).

¹³ In BC and across Canada in 2011: Approximately 34% of Indigenous children lived in a single-parent family compared with 17% of non-Indigenous children. The majority of single-parent families in Canada (among both Indigenous and non-Indigenous families) are headed by women (Statistics Canada, 2013, 2014).

great deal of mobility both within and between cities, and back and forth between urban centers and reserves, or rural communities (Browne, McDonald, & Elliott, 2009). Also as Peters and Anderson (2013) emphasize, “ancestral homelands are not contained by the small parcels of land found in reserves. . . rather, they are the larger territories that include contemporary urban settlements” (p. 8).

2.2.1 Historical, Political, and Socio-Economic Structural Inequities

As Greenwood (2005) reminds us: “One cannot examine the health and well-being of Aboriginal children without understanding and acknowledging their unique social, political and historical context” (p. 553). Salient to the questions posed by this dissertation research is an understanding of how family well-being and health inequities affecting children are determined by intersecting historical, political and socio-economic structural inequities. In the following section, I provide an overview of how colonization, “as the broadest and most fundamental determinant of Indigenous health and well-being in countries where settler-colonial power continues to dominate” (de Leeuw et al., 2015, p. xii), intersects in complex and differential ways with socio-economic oppression and neoliberal modes of governance to adversely impact the lives of Indigenous women and their children’s opportunities for health and well-being in childhood and beyond (de Leeuw & Greenwood, 2011; Reading & Wien, 2013). I also draw attention to how these inter-related structural inequities create and sustain structural violence in families’ lives.

2.2.1.1 Residential Schools, the ‘Sixties Scoop’, and Contemporary Child Welfare

Prior to colonization, many Indigenous peoples raised, cared for, and educated their children within an extended and interdependent system of relationships, which helped to ensure children’s safety and well-being (Castellano, 2002; Connors &

Maidman, 2001; Irvine, 2009). Colonization insidiously disrupted family networks and ‘disconnected and dislocated’ individuals, families, and communities from their traditional lands and the intergenerational transmission of Indigenous knowledges and cultures (Stout, 2012). A significant number of Indigenous families and communities, continue to work towards overcoming the detrimental and multi-layered effects of intergenerational trauma from destructive state¹⁴ intervention (Hardy, 2013; Haskell & Randall, 2009).

Pertinent to this dissertation is the literature that links intergenerational trauma, as a result of state intervention in Indigenous families’ lives, with disrupted maternal-infant attachment¹⁵ (Hardy, 2013; Haskell & Randall, 2009; Ing, 2006; Pearce et al., 2008).

Understanding how EI supports families in ways that take into account and mitigate the influence of historical and ongoing state surveillance and intervention on their daily lives is also central to the questions posed by this research.

Under-pinned by assimilation and protection, state intervention in families’ lives has been and continues to be “entrenched in the history of relations between Aboriginal peoples and the nation-state” (Adelson, 2005, p. 45). For over 100 years, the state attempted to assert Canada’s nationhood and manage ‘the Indian problem’ through a legislated and mandatory residential school system (Furniss, 2000). Children as young as

¹⁴ In using the term ‘state’, I am drawing on the work of Fiske who notes that, “we have yet to find an alternative concept to describe the comprehensive power exerted by governing authorities over citizens’ daily lives” (2006, p. 248).

¹⁵ Maternal experiences of stress, anxiety, and depression during pregnancy or early parenting can disrupt women’s attachment with their newborns and infants (Charil, Laplante, Vaillancourt, & King, 2010; Monk, Spicer, & Champagne, 2012). Research on attachment has focused on mothers. However, infants and children can form attachment relationships with any caregiver who provides regular parenting care. Maté describes attachment as the most important relational dynamic in human life and critical to health in childhood and across the life course (2013).

five were removed, often by force, from their families and home communities and ‘educated’ through state funded, church-run residential schools¹⁶ (Royal Commission on Aboriginal Peoples, 1996a; Truth and Reconciliation Commission of Canada, 2015). Okanagan activist Armstrong has described this system as “the single most devastating factor in the breakdown of our society. It is at the core of the damage, beyond all the other mechanisms cleverly fashioned to subjugate, assimilate, and annihilate” (1996, p. x). Many of the children were physically punished, emotionally traumatized, sexually abused, and denied the opportunity of having healthy and loving relationships with their siblings, parents, and extended family (Haig-Brown, 1988; Royal Commission on Aboriginal Peoples, 1996a; Truth and Reconciliation Commission of Canada, 2015). Consequently, as adults, many struggled to care for themselves or their children (Cull, 2006; Ing, 2006).

As residential schools closed in the second half of the 20th century, the government instituted a new approach to the assimilation of Indigenous children that is commonly referred to as the ‘Sixties Scoop’¹⁷. Between 1960 and 1990, it is estimated that over 11,000 children were adopted by non-Indigenous families who often lived in a different province or sometimes a different country (Trocmé, Knoke, & Blackstock,

¹⁶ Eighteen residential schools were built in BC, operating for over 120 years. The longest running institution, St. Mary’s Indian Residential School in Mission, operated between 1861 and 1984. The schools were operated in partnerships between the federal government and Catholic, Methodist, Anglican, and Presbyterian churches, with the explicit goal of transforming Indigenous children into ‘de-indigenized’ adults (de Leeuw, 2009).

¹⁷ Beginning in the 1960’s “the federal government effectively handed over the responsibility for Indigenous health, welfare, and education services to the provinces” while remaining financially responsible for on reserve First Nations and Inuit peoples (Kirmayer et al., 2009, p. 10). In 1959, 1% of children who were legal wards of the state were Indigenous (Fournier & Crey, 1997). By the end of the 1960s, this number had risen to 30-40% (Fournier & Crey, 1997).

2004). Thousands of children grew up denied of their families, communities, ancestry, and cultural identity (Trocmé et al., 2004).

Historically constituted state intervention in Indigenous children's lives continues today through the contemporary child welfare system¹⁸ (Tait, Henry, & Loewen Walker, 2013). This system has largely ignored the role of prevention in promoting the health and well-being of vulnerable children (Hughes, 2013a; Pringle, 2010; Tait et al., 2013; Truth and Reconciliation Commission of Canada, 2015). Today, child welfare has been described as constituting 'a broader colonial system' that has become "so fully naturalized as to be mostly invisible, especially to settler-colonists" (de Leeuw, 2014, p. 60). Conceptualizing the number of Indigenous children in 'state care' as a quantitative marker of the structural violence of the current child welfare system, highlights how routine and seemingly taken for granted state-sanctioned policies and practices continue to create suffering and injustices for Indigenous families and their children.

Across Canada, there are now more Indigenous children being removed from their families than at the peak of the residential school system (Blackstock, 2011). A major contributing factor for families living on reserve, is an inequitable distribution of child welfare funding¹⁹ and resources (Blackstock, 2011, 2013). Indigenous mothers who are young, single, and living in impoverished conditions are more likely to experience state surveillance and/or have their children removed from their care compared to their non-

¹⁸ In BC, child welfare is governed within the legal framework of the Child, Family, and Community Service Act, which was originally passed in the Legislative Assembly in 1996 and amended through to include 2011. Child welfare in BC is administered and funded through the Ministry of Children and Family Development (Representative for Children and Youth, 2013).

¹⁹ BC, along with New Brunswick and the Yukon, has the lowest level of funding for child welfare in Canada (Blackstock, 2013).

Indigenous counterparts (Sinha, Ellenbogen, & Trocmé, 2013a; Sinha et al., 2011). As Hughes (2013) notes, although “the root causes of neglect . . . lie beyond the scope of the child welfare system to resolve”, greater collaboration between parents, the child welfare system, provincial government departments and community-based organizations, could “make a difference for vulnerable families” (p. 28).

Indigenous families are investigated for abuse or neglect at a rate four times higher than non-Indigenous families in Canada (Sinha et al., 2013a). State intervention for ‘child neglect’ frequently locates responsibility for change at the level of individual parents typically in the form of mandated parent education (Russell, 2011). Reinforcing the need for change at the level of individual families, draws attention away from the responsibility of the state to promote social equality and justice (McKeen, 2011). In this socio-political context, families who experience multiple forms of marginalization rooted in structural inequities are further punished by a child welfare system that places their children at potentially greater risk (de Leeuw, 2014; Hughes, 2013a; Representative for Children and Youth, 2013; Tait et al., 2013).

In BC, Indigenous children represent 8% of the total child population but 53% of children living in ‘out-of-home care’ (Representative for Children and Youth, 2013). Indigenous children in care have significantly lower educational outcomes compared to children who have never been in care (Brownell, Chartier, Au, MacWilliam, & Schultz, 2015). In BC, a disturbing finding of the Office of the Provincial Health Officer (2009), is that Indigenous children with special needs ‘enter state care’ primarily to access

services that are otherwise unavailable in their home communities²⁰. Even more alarming is the number of Indigenous infants who have died²¹ while in some form of state ‘care’ in this province (Representative for Children and Youth, 2011).

The failure to address the increasing number of Indigenous children in ‘Ministry care’ in BC is a strong indication that early prevention in this province is failing and suggests that many families are not getting the supports they need (Representative for Children and Youth, 2013, 2014). As Tait and colleagues (2013) state:

“The inability (or unwillingness) of governments to create effective poverty-reduction strategies and the continued focus of the child welfare system on crisis situations rather than preventative measures, compounds the risk that vulnerable Indigenous families face, permanently losing their children to the child welfare system” (p. 40).

Currently the provincial Ministry in BC responsible for child welfare services, the MCFD, continues to lack a policy framework, and targeted funding for prevention services (Representative for Children and Youth, 2013).

2.2.1.2 Racialization

Caribbean-born French psychiatrist Fanon²² (1967) initially coined the term racialization to describe the ideological process whereby racial identity is assigned to an individual or population group. As a central feature of colonization, racialized discourses

²⁰ This finding is corroborated by a recent study that reported 11% of Indigenous children in care in Manitoba had a developmental disability and 32% had a ‘mental disorder’ compared to 1.5% and 7.7% respectively of children who had never been in care (Brownell et al., 2015).

²¹ Between 2007 and 2009 in BC, 21 infants under two years of age died while, in some capacity, living within the purview of the MCFD. An alarming number, 15 of the 21, were Indigenous infants (Representative for Children and Youth, 2011).

²² Drawing on his personal experiences of being ‘walled in’ by the color of his skin, Fanon (1967) published several influential works on the construction of racism as a form of colonial oppression and subordination (Ashcroft, Griffiths, & Tiffin, 2007).

legitimized colonial rule and asserted Eurocentric privileges over an essentialized, inferior, and subordinate ‘Other’ (Ahmad, 1993; Memmi, 1969; Young, 2001).

Racialization “takes its power from everyday actions and attitudes and from institutionalized policies and practices that marginalize individuals and collectives on the basis of presumed biological, physical, or genetic differences” (Browne, Smye, & Varcoe, 2005, p. 21). Racialization is a feature of contemporary Canadian social dynamics that can be experienced by different individuals or population groups.

Racialization may be conscious and deliberate, an act of racism that discriminates openly, or unconscious and unintended (Browne, Smye, & Varcoe, 2005). In this dissertation, racialization is conceptualized as a form of structural violence because of its profound impact on the health and well-being of Indigenous peoples in Canada (Allan & Smylie, 2015). Understanding how EI supports women’s agency in dealing with the ongoing effects of racialization in their daily lives, particularly as they navigate the institutions of child welfare and health care, is salient to the questions posed by this study.

In the context of the child welfare system, it has been argued that the perpetuation of state power through mechanisms of surveillance²³ and intervention in children’s lives is structured through enduring patriarchal and racialized discourses that portray Indigenous women as ‘unfit’ mothers and their children as ‘at risk’ (Cull, 2006; de Leeuw, 2009, 2014; Kelm, 1998). Racialized discourses can have serious consequences for Indigenous families and their children, particularly when ‘child neglect’ is constituted

²³ Surveillance is a powerful strategy of colonization as “it implies a viewer with an elevated vantage point” who has the power to define and objectify the colonized subject “in a way that fixes its identity in relation to the surveyor” (Ashcroft et al., 2007, p. 226).

as an ‘Indigenous characteristic’, rather than as a consequence of structural inequities (Cull, 2006; Fiske & Browne, 2006).

In the context of health care, racialization is a highly complex process in which historically constituted unequal power relations between Indigenous peoples and the state play out in routine health care encounters (Allan & Smylie, 2015; Herring, Spangaro, Lauw, & McNamara, 2013; Tang & Browne, 2008). Research shows that Indigenous women’s access to equitable health and health care are frequently constrained by their experiences of racialization, which are often interwoven, or continuous, with other forms of structural and interpersonal violence, including intergenerational trauma, poverty, and intimate partner violence²⁴ (IPV) (Browne et al., 2011b; Browne, Varcoe, & Fridkin, 2011c; Halseth, 2013; Kurtz, Nyberg, Van Den Tillaart, & Mills, 2008; van Herk, Smith, & Andrew, 2011b). These studies highlight how racialization contributes towards a higher prevalence of chronic health conditions amongst Indigenous women, including higher rates of diabetes, HIV infection, mental illness and substance use (Browne et al., 2011c; Halseth, 2013; Varcoe & Dick, 2008).

The inextricable nature of maternal-infant health, suggests that the multifaceted effects of racialization on Indigenous women’s health could have a detrimental effect on the health and well-being of their children (Kurtz et al., 2008). As gatekeepers to their children’s health, health care encounters that result in Indigenous women feeling disempowered, judged, and traumatized may also constrain their children’s access to

²⁴ The Native Women’s Association of Canada (2007) reports that Indigenous women are three times as likely to report IPV, and are eight times more likely to be killed by their spouse after a separation compared to other women in Canada. These statistics raise concerns that Indigenous children are significantly more likely to witness IPV compared to other children in Canada.

equitable health outcomes and care (Denison, Varcoe, & Browne, 2013; Lynam et al., 2010; van Herk et al., 2011b).

2.2.1.3 The Structural Violence of Socio-Economic Oppression

The effects of socio-economic inequities on Indigenous families and children's lives, and the implications for EI, are highly relevant to the questions raised by this research. As an analytical lens, the concept of structural violence exposes how political structures that result in an inequitable distribution of socio-economic resources create conditions of material and social disadvantage and exclusion, violate human rights, constrain human agency, and perpetuate health inequities at individual and populations levels (Anaya, 2014; Farmer et al., 2007; Ho, 2007; National Collaborating Centre for Aboriginal Health, 2009; Roberts, 2009; Stout, 2012).

The socio-economic status of Indigenous families varies greatly (Place, 2012). However, intersecting structural inequities that include inter-generational trauma from state intervention in families' lives, outdated legislation and policies governed by the Indian Act²⁵, and a failure of funding to keep pace with a fast growing population have contributed to the pervasive socio-economic oppression of many Indigenous communities and families (First Nations Information Governance Centre, 2012; Fontaine, 2007). The structural nature of socio-economic marginalization and oppression has produced pervasively high levels of unemployment and poverty that far exceed the Canadian

²⁵ The Indian Act of 1876, "historically and currently limits the legal category of "Indian," which, in turn, determines who has the right to live on-reserve, access Indian-specific federally funded programs and services, and qualify for certain individual-based health, social, and education benefits" (Lavoie, Forget, & Browne, 2010, p. 86).

average²⁶ (First Nations Information Governance Centre, 2012). This is amplified for Indigenous women, many of whom struggle to meet their basic needs and experience a high incidence of food and housing insecurity (First Nations Information Governance Centre, 2012; Native Women's Association of Canada, 2004, 2007). Evidence indicates that many Indigenous children, during the most critical years of their development, live in impoverished conditions (Macdonald & Wilson, 2013). Although the reported percentage of Indigenous children who live in poverty²⁷ varies between studies, the rate of poverty experienced by this population is consistently higher than other child populations in BC and Canada (Canadian UNICEF Committee, 2009; Representative for Children and Youth, 2014). One recent study reported the rate of poverty amongst Indigenous children in Canada as 40%, compared to a national average of 7% (Macdonald & Wilson, 2013).

2.2.1.3.1 Neoliberal Modes of Governance

In BC and across Canada, neoliberal²⁸ modes of governance, as they shape social and welfare policies defer “responsibility from the public/macro-scale to the private/micro or family scale” (Gurstein & Vilches, 2011, p. 226). Neoliberal ideology is underpinned by the assumption that decisions and choices are under individual’s control, regardless of social constraints (McKeen, 2011). In this political context, economic

²⁶ The average annual household income for the Canadian population is \$75,880, whereas approximately 43% of Indigenous households have to survive on less than \$20,000 a year (First Nations Information Governance Centre, 2012).

²⁷ “Households that earn less than 50% of the median adjusted house-hold income for their household size are said to be living in poverty. This is a widely-used measure internationally” (First Call: BC Child and Youth Advocacy Coalition, 2014, p. 6).

²⁸ Neoliberalism is a Western political ideology grounded in a fundamental philosophy of contemporary capitalism that has been pursued by Canada since the mid-1980s. It is rooted in the theory that the best approach to securing and protecting human well-being is through individual economic and social freedoms and minimal state intervention in market activities (Griffin Cohen & Pulkingham, 2011).

inequalities are depoliticized as poverty is construed as an individual shortcoming, and ‘getting out of poverty’ as the personal responsibility of individuals who are often portrayed as ‘choosing’ a lifestyle of living on welfare rather than contributing towards the labor economy (McKeen, 2011; Russell, 2011).

In 2008, Canada ranked last out of 25 countries on policies aimed at supporting families (UNICEF Innocenti Research Centre). As a recent environmental scan undertaken by the BC Aboriginal Child Care Society (2014) concludes, there is an “apparent lack of political will on the part of both the federal government and the BC provincial government to implement policies and programs that would create fundamental change in the lives of young Aboriginal children and their families” (p. 9). Family policy and gender equality go hand in hand; countries that have weak family policies have greater gender inequality (L. Anderson, 2012). Poverty has been a persistent and historically gendered problem in BC, particularly for female-led single-parent families (Graham, Atkey, Reeves, & Goldberg, 2009). The lack of a provincial action plan to address disturbing high rates of poverty amongst families and children, and increasingly severe cuts to BC’s social and welfare policies, have created conditions of social disadvantage and marginalization for female-led single-parent families (First Call: BC Child and Youth Advocacy Coalition, 2014; Gurstein & Vilches, 2011; Representative for Children and Youth, 2013). The gendered nature of poverty in BC is a serious concern given that many Indigenous children are growing up in single parent families headed by women (Statistics Canada, 2013). Evidence indicates that Indigenous women who leave reserve communities as a result of relationship breakdowns and/or IPV move to urban centers where they often lack a support network in raising their children

(Native Women's Association of Canada, 2007). For women who are raising their children without a support network, their vulnerability is compounded by BC childcare policies²⁹, that construe early childcare as a private responsibility (Bennett, 2011), and constrain their agency in being both a financial provider and caregiver to their children (Gurstein & Vilches, 2011). As a result, families and children who could benefit the most from childcare have the least access (Beach & Bertrand, 2000; Prentice, 2007).

2.2.1.3.2 The Impact of Socio-Economic Inequities on Children's Health

The structural violence of socio-economic inequities that arise from neoliberal modes of governance is evident when one considers the effects of poverty on infants and children's early health, developmental trajectory, and life course. The international evidence correlating child health with a linear socio-economic gradient is compelling (Blackburn, Spencer, & Read, 2013; Hertzman, 2010; Raphael, 2011; Ziol-Guest, Duncan, Kalil, & Boyce, 2012). Young children pay the highest cost of socio-economic structural inequities, as infant mortality rates³⁰ and young children's health and development are particularly sensitive to the socio-environmental conditions of their early years (Blackburn et al., 2013; Marmot & Allen, 2014). This explains why rates of mortality are so high amongst Indigenous infants. In BC, the average infant mortality rate is four infant deaths per 1,000 live births (Office of the Provincial Health Officer, 2009). For Indigenous infants living on reserve, the rate increases to five to six deaths per 1,000 live births; it doubles to 10 deaths per 1,000 live births for infants living off reserve, and

²⁹ "Provincial child care subsidy rates for low-income families are not tied to the actual costs of care, nor are they reviewed annually for adequacy" (Graham et al., 2009, p. 7).

³⁰ The 'infant mortality rate' refers to the number of deaths of babies in their first year expressed as a rate per 1,000 live births, and is an established indicator of the overall health of a population (Marmot, 2011).

is more likely to be attributable to preventable causes compared to non-Indigenous infant deaths (Office of the Provincial Health Officer, 2009). Both abnormally low and high birth weights are also more prevalent for Indigenous newborns compared to other newborns in BC (Office of the Provincial Health Officer, 2009).

The longer children live in poverty the greater the risk to their health and well-being in childhood and across their life course (Knudsen, Heckman, Cameron, & Shonkoff, 2006). The effects of socio-economic inequities on children's health and well-being can also be compounded by the multifaceted negative effects of chronic poverty and social marginalization on their parents' mental and physical health and well-being (Dietrich-Leurer, Abonyi, & Smadu, 2013; McGibbon & McPherson, 2011).

International evidence is strengthening the link between growing up in poverty with an increased incidence and severity of early developmental delays and disabilities, and poor physical, mental health, and early learning outcomes (Blackburn et al., 2013; McPherson & McGibbon, 2010; Raphael, 2011; Richter-Kornweitz, 2010). The health statistics³¹ available for Indigenous children that show high rates of respiratory problems, childhood obesity and diabetes, and accidental injury and death have all been linked to the multifaceted effects of growing up in impoverished conditions (Office of the Provincial Health Officer, 2009; Public Health Agency of Canada, 2001, 2011; Saylor, 2004). The experience of growing up in impoverished conditions has serious and potentially life

³¹ Population level data on Indigenous children's health and well-being needs to be used extremely cautiously because of the limitations of available data, and the tendency for decontextualized health statistics to perpetuate deficit-orientated stereotypes (Canadian UNICEF Committee, 2009). The government also lacks comprehensive health statistics and "well-being indicators comparing Aboriginal and non-Aboriginal populations. The lack of accessible data on comparable health indicators means that these issues receive less public, media, and political attention" (Truth and Reconciliation Commission of Canada, 2015, p. 208).

changing consequences for Indigenous children as it is associated with an increased risk of being placed in ‘state care’ (Sinha, Trocmé, Fallon, & MacLaurin, 2013b) .

In this section of the chapter, I have highlighted how intersecting structural inequities constitute forms of structural violence as they create and sustain poor health outcomes for Indigenous women, and conditions of social disadvantage that give rise to health inequities affecting their children. While it is important to understand the complex and multifaceted ways in which Indigenous women’s health and their roles as mothers and caregivers can be adversely impacted by a complex interplay of multifaceted social and structural factors, it is equally important to recognize their agency, strengths, and resistance (K. Anderson, 2000; Green, 2007). As Maracle (2003) points out, Indigenous women frequently play a leadership role in many urban and on reserve communities and continue to be at “the cutting edge of our development and the voice that challenges our inequity” (p. 77). There is also promising evidence that pregnancy and early parenting represent a significant opportunity for Indigenous women to both resist and heal from the intergenerational trauma of the residential school system (D. Smith, Edwards, Varcoe, Martens, & Davies, 2006; D. Smith, Edwards, Martens, & Varcoe, 2007). Raising healthy Indigenous children is recognized as being key to restoring and revitalizing community and family well-being, and support networks damaged by colonization (Castellano, 2002; Greenwood & de Leeuw, 2007).

2.3 Critical Perspectives on Early Childhood

In the following section of this chapter, I critique the normative construction of early childhood. This critical analysis is consistent with the theoretical framing of this study, as discussed in Chapter Three, and provides an important foregrounding for

understanding some of the salient issues in relation to Indigenous early childhood programs.

2.3.1 A ‘Sacred Western Lens’: The Normalizing Construction of ‘Childhood’

Contemporary prevailing knowledge on early childhood privileges the perspectives and experiences of middle-class, White, Christian, families living in western European and North American urban contexts (Cannella & Viruru, 2004; Dahlberg et al., 2006; Pacini-Ketchabaw, 2010; Soto & Swadener, 2002; Woodhead, 2011). This ‘sacred Western lens’ (Cannella & Viruru, 2004) has informed the construction of ‘a scientific child’ who progresses through developmental stages and milestones that are assumed to be universal for all child populations (Dahlberg et al., 2006; Einboden, Rudge, & Varcoe, 2013; Niles et al., 2008). Dominant early childhood discourses promote standardization, predictability and control; “they express a desire for a clean and orderly world, devoid of messiness and complexity” (Dahlberg et al., 2006, p. 2). The dominant construction of early childhood also erases Indigenous children’s history and identity (Diversi & Moreira, 2012).

A consequence of this intellectual hegemony³² is that this seemingly ‘common sense’ understanding of early childhood is reproduced through prevailing early childhood practices, state priorities, and policies (Dahlberg et al., 2006; Viruru, 2005). While normative assumptions are reified as ‘scientific knowledge’, the knowledge and perspectives of people who have less recourse to social power, are generally regarded as

³² Hegemony as identified by Gramsci, an Italian Marxist scholar in the 1930s, refers to a way of thinking that occurs when a dominant group’s vision of reality is taken up uncritically as a ‘commonsense’ ideology and applied universally regardless of its validity (Gramsci, 1978).

less than scientific or ‘best practice’ (Niles, Byers, & Krueger, 2007; Soto & Swadener, 2002). “Rather than building from the particular and allowing these local voices to form and shape ‘what is important’ and ‘what we need to know’, positivist practices privilege the few with access to the tools, methods, and dollars that shape and perpetuate uniform policies, programs, research and practices” (Pence & Pacini-Ketchabaw, 2008, p. 245). In this way, ‘expert knowledge’ is reproduced through a ‘hierarchy of subjects and knowledges’ (Gandhi, 1998).

2.3.2 Children as Human Capital

In recent years, the dominant construction of early childhood has been increasingly tied to Western narratives of productivity and economic stability (Einboden et al., 2013). Childhood is viewed as a critical period of opportunity or risk for children’s future participation in national economic growth (Hertzman & Bertrand, 2007; Knudsen et al., 2006; Shonkoff, 2010). The focus is on producing “well educated and highly resourceful adults who are capable of learning new skills so that they remain competitive in a continually changing global market”(Shonkoff, 2010, p. 358). It has been argued that this perspective, objectifies children as (re)producers of skills and knowledge and maintains the state’s role in containing and shaping early childhood (Einboden et al., 2013).

Integral to an economic perspective of early childhood, is the prioritization of ‘school readiness’ (Early Learning Advisory Group, 2008). Research in BC suggests that although Indigenous families view early education as key to alleviating poverty in their communities, they are concerned that externally designed school readiness programs, with a narrow focus on early literacy, numeracy, and English language skills, pre-empt

holistic health, cultural rejuvenation, and self-determination (Ball & Le Mar, 2011). Indigenous families have voiced their skepticism that dominant Western knowledge about child development is the ‘right, best, and only way’, and expressed their concerns that privileging this knowledge reproduces state interference in their children’s lives (Ball & Le Mar, 2011).

2.3.3 A ‘Silent Crisis’: Developmental Screening

Using only a dominant worldview of early childhood as the normative standard, disregards children’s socio-cultural, historical, and geographical identities and positioning (Prout & James, 1997; Rogoff, 2003; Woodhead, 2011). Niles and colleagues (2008), describe a ‘silent crisis’ in which developmental and bio-medical theories of child development are used uncritically with Native American children to assess for, and diagnose, developmental delays and disabilities.

In BC, ‘standardized’ early developmental screening tools, such as the ‘Ages and Stages Questionnaire³³’ or ASQ (Brookes Publishing Co., 2012), are used in the majority of Indigenous early childhood settings (Ball, 2008a; British Columbia Aboriginal Child Care Society, 2013). Despite not being empirically validated with an Indigenous child population, the ASQ has been approved and promoted by provincial and federal funding agencies (Ball, 2007). Concerns have been raised that their use with Indigenous children reproduces decontextualized and normative expectations of children’s development, and deficit-orientated diagnostic labels, as young children are measured and judged against

³³ The ASQ is an American standardized developmental screening tool that looks at a child’s development in the domains of communication, gross motor, fine motor, problem solving (Brookes Publishing Co., 2012).

‘normative standards’ (Ball, 2007; Niles et al., 2007). In addition, increased developmental screening frequently does not result in increased access to EI programs (Ellison, 2008). Also, anecdotal evidence suggests that screening results are implicated in decisions by child welfare services to remove Indigenous children from their homes because of ‘evidence’ of development delays.

2.4 An Introduction to Early Intervention

It has been argued that the establishment of a comprehensive range of early childhood programs in Canada “would be the single best way of improving Canadian health outcomes” (Raphael, 2010, p. 73). During the early years of life, infants’ early experiences, particularly their interactions with their caregivers, the level of sensory stimulation and routine, and access to a nutritional diet have a profound influence on their development (Miller et al., 2011; SAMHSA, 2012; Shonkoff & Phillips, 2000). In recent years, rapidly expanding research into epigenetics³⁴ has provided further evidence of the relationship between various socio-environmental conditions and factors in the early years with adult health and well-being (Blackburn et al., 2013; Chen, Miller, Kabor, & Cole, 2011; Hertzman, 2010; Shonkoff et al., 2009). This research challenges governments to provide proactive EI for children as early as possible, ideally in the prenatal period, in order to reduce “inequalities in the early years so as to prevent the

³⁴ Epigenetic mechanisms are “molecular modifications to gene activity that do not involve changes to the underlying DNA sequence. . . . Recent evidence indicates that epigenetic variation can be induced across the life span in response to a broad range of environmental exposures” (Monk et al., 2012, p. 1361).

further acceleration of these problems later in life” (Doyle, Harmon, Heckman, & Tremblay, 2009, p. 2), and to extend EI well into early childhood (Goldblatt et al., 2015).

Extensive evidence demonstrates that comprehensive early childhood policies and funding, and high quality ECD and EI programs, can significantly improve the quality of life and developmental outcomes for infants and young children living in difficult socio-economic circumstances (All Party Parliamentary Sure Start Group, 2013; Hertzman, 2013; Shonkoff, 2010; Siddiqi et al., 2011). This evidence resonates with growing calls in Canada for funding to be directed to earlier and more proactive forms of targeted EI in order to build on Indigenous families’ strengths and ‘protect vulnerable children’ (Hughes, 2013a; Pringle, 2010; Representative for Children and Youth, 2013).

Frequently, the need for early ‘preventative’ forms of intervention, particularly for families who are living in conditions of social disadvantage, are justified by the future economic benefits to governments and society (Doyle et al., 2009; Nores & Barnett, 2010; Olds, 2006; Shonkoff, 2010). In this discourse, the need to target ‘at risk children’, as a prominent rationale for EI, is based on the assumption that children’s health and well-being can be transformed primarily by targeting ‘at risk’ populations at an individual level (Ellison, 2008). This discourse discursively locates blame and pathology at the individual level of the child and frequently fails to take into account or address the structural and material realities and historical contexts that shape families and children’s lives (Ellison, 2008; Harris, 2008; McKeen, 2011).

EI programs are highly varied in their approach; there is no one model. However,

the mantra of being ‘family-centered’³⁵ is used by funding agencies, and a wide range of early childhood and EIT programs, to describe a set of ideas of how services are delivered for children and families (Bruder, 2000; Shields, Pratt, & Hunter, 2006). It has been argued, however, that EI providers whose educational and experiential knowledge have focused primarily on biomedical paradigms, frequently expect families “to assimilate to the cultural imperatives of the early interventionist” (Vacca & Feinberg, 2000, p. 40). Families that resist or fail to engage in ‘family-centered’ intervention may be viewed as disinterested or noncompliant (Vacca & Feinberg, 2000).

EI programs may be provided through home-visiting, outreach, or centre based models. The high variability in how EI is provided in different family and geographical contexts, makes it challenging to generalize research findings from one program to another (A. Barlow et al., 2013; Karoly, Kilburn, & Cannon, 2005). A recent systematic review, the first of its kind, to identify EIs that had the potential to reduce child health inequities in European countries, concluded that effective interventions were: universally accessible but tailored to families’ social and economic circumstances, recognized parents’ knowledge and capacities concerning their children’s development, combined programs and workshops for both parents and children, started during pregnancy, and included a home visiting component (Morrison, Pikhart, Ruiz, & Goldblatt, 2014). It is beyond the scope of this study, to discuss the vast amount of multi-disciplinary literature

³⁵ Distinguishing features of a family-centered approach included a focus on collaborative relationships between caregivers and early interventionists, a focus on family strengths, and giving families’ choices in relation to intervention (Bruder, 2000). Evidence suggests, however, that ‘family-centered’ is used so ubiquitously in diverse professional and practice settings that the meaning and outcomes of being ‘family-centered’ remain unclear (Carter, 2008). Furthermore, that ‘child outcomes’ continue to take precedence over more broad based family outcomes and support strategies (Bruder, 2000).

on various EI approaches. Rather, in the following section of this chapter, I highlight some of the key issues in the literature that are pertinent to this study.

2.4.1 Home-Visiting Programs

Many EI programs, including AIDPs, are provided primarily through a home-visiting model of service delivery. It has been suggested that the individualization inherent in a home-visitation model of service delivery, versus one that is group-oriented and/or centre-based, is more likely to engage ‘hard to reach’ families and be responsive to the distinct circumstances, challenges, and strengths of individual families (Astuto & Allen, 2009; Korfmacher et al., 2008). The evidence on EI home-visiting programs originates predominately from programs that have been developed for non-Indigenous populations (Eni, Prakash, & Senecal, 2009; Niles et al., 2007). The literature on home-visiting indicates that programs that build on mothers’ capacity to support their children’s health, well-being, and development provide an important mechanism for reducing the lifelong effects of early childhood adversity (Garner, 2013).

Research on home-visiting programs has focused primarily on documenting intervention outcomes rather than on understanding how families’ perceive and experience this form of service delivery (Korfmacher et al., 2008). However, there is some evidence to suggest that effective home-visiting programs: start at pregnancy, last more than a year; involve ‘specially trained staff’, and focus on building trustworthy relationships and modeling infant-caregiver interactions (Kotliarenco, Gómez, Muñoz, & Aracena, 2010). In a 2007 qualitative study in the US, parents (N=90) of infants ‘at risk for developmental delays or maltreatment’ described their perceptions of ‘assets and barriers’ to home-visiting intervention practices (Allen, 2007). Findings highlight that

parents valued: close parent-provider relationships, ‘ready accessibility’ of the home visitor, parenting education, and an array of service co-ordination interventions (Allen, 2007). Parents also voiced their concerns that program’s lacked the resources to meet their material needs (Allen, 2007).

Currently, much of the literature on home visiting is based on nursing research and on home-visiting programs provided by nurses (Heaman, Chalmers, Woodgate, & Browne, 2006). A landmark study by Olds and colleagues (2004) in the United States (US), has had a pervasive influence on perinatal and infant home-visiting programs internationally. This study involved low-income African American, Caucasian, and Hispanic families (N=735), who were randomly assigned a ‘paraprofessional³⁶’ or a nurse to provide a home-visiting program that was based on a model originally developed for nurses to deliver (Olds et al., 2004). One of the key findings of this study was that “paraprofessionals produced small effects that rarely achieved statistical or clinical significance” whereas “nurses produced significant effects on a wide range of maternal and child outcomes” (Olds et al., 2004, p. 486). This study informed the development of Nurse-Family Partnership (NFP) programs for pregnant and early parenting (up to age two) ‘at risk’ mothers (Olds, 2006). Longitudinal research has shown that children who receive NFP programs have improved intellectual functioning and receptive vocabulary and reduced behavioral problems (Olds, 2006).

³⁶ In this study, paraprofessional visitors were required to have a high school education and were described as sharing “many of the social characteristics of the families they serve” (Olds et al., 2004, p. 487).

A concern that NFP programs could not be replicated ‘in low-resource, culturally diverse communities’ where there is frequently a shortage of nurses or health care professionals, was one of the driving forces behind research on the ‘Family Spirit’ program in the US (A. Barlow et al., 2013). This program is described as a ‘culturally-tailored paraprofessional delivered home-visiting intervention’ program for Native American teenage mothers³⁷ (A. Barlow et al., 2013). The program is highly structured and centered on 43 ‘positive parenting lessons’ that start during pregnancy and extend to 36 months postpartum (A. Barlow et al., 2013). An educational approach to EI is also evident in the ‘Families First’ home-visiting program in Manitoba which is based on a curricula, ‘Growing Great Kids’ and ‘Growing Great Families’³⁸ (Great Kids Inc, 2014). These prescriptive and educational forms of EI home-visiting programs, as they align with neoliberal individualism, appear to be in stark contrast to how AIDPs have evolved. Currently, there is a distinct gap in the literature on home-visiting EI programs for Indigenous families and children in Canada.

2.4.2 Early Intervention Therapy Programs

As an occupational therapist, I have provided EI in diverse community and family contexts, including in several First Nations communities in southwestern BC. The primary focus of EI occupational therapy is to maximize a child’s potential to engage and

³⁷ In this study, paraprofessionals were required to have a high school education and at least two years of relevant work experience (A. Barlow et al., 2013). Outcomes of a three-year randomized controlled trial (N=322) undertaken in four southwestern reservation communities concluded that the program promoted effective parenting, reduced maternal risks, including substance use and dropping out of school, and improved child developmental outcomes (A. Barlow et al., 2013).

³⁸ ‘Growing Great Kids’ and ‘Growing Great Families’ is a non-profit organization in the US that aims to provide home visitors with the ‘right tools’ and knowledge on ‘how to use them’(Great Kids Inc, 2014).

participate in meaningful and age appropriate occupations³⁹ that may include playing, interacting with peers, and self-care activities in their home and community settings, such as a playground or daycare (Case-Smith & O'Brien, 2010). Increasingly occupational therapy theorists are calling for professional knowledge, theories, and practices to move beyond their Eurocentric, primarily White, middle-class, and female oriented perspectives of occupation and health (Gerlach, 2012, 2015; Hammell, 2011; Iwama, 2007; Kronenberg, Simo Algado, & Pollard, 2005; Whiteford, 2007). In recent years, there has been a slow but growing international interest in how to provide occupational therapy with and for Indigenous peoples (Booth & Nelson, 2013; Gerlach, Sullivan, Valavaara, & McNeil, 2014b; Hopkirk & Wilson, 2014; Jull & Giles, 2012; Nelson & Allison, 2007). The relationship between occupational therapy and diverse Indigenous knowledges and perspectives on health and well-being has yet to be explored.

EI that is provided by an occupational therapist, physiotherapist, or speech and language pathologist for infants and preschool aged children with developmental delays or disabilities, and/or chronic health conditions is commonly referred to as 'early intervention therapy' (EIT). In BC, EIT programs and services are often located in child development centers, and are funded through the MCFD. Typical services include:

“developmental screening; referral; assessment; family education and support; service

³⁹ From an occupational therapy perspective, “occupation is used to mean all the things that people need, want or have to do” in their everyday lives (Wilcock, 2006, p. xiv). It is viewed as a multidimensional, value-laden, and interactive process between people and their socio-cultural, physical, and natural environments (Wilcock, 2006). Participation in meaningful occupations is viewed as essential to individual and collective health and well-being (Durocher, Rappolt, & Gibson, 2013).

planning; direct therapeutic intervention; consultation; monitoring; transition planning, and community training” (Ministry of Children & Family Development, 2013, p. 19).

EIT has been identified as a priority in improving the health of Indigenous children in BC who have, or are at risk of having, developmental delays or disabilities (First Nations Early Childhood Development Council, 2009, 2011; Gerlach et al., 2009). There are, however, serious gaps in service delivery for Indigenous children who could benefit from specialized EIT (Ball, 2008b; First Nations Early Childhood Development Council, 2009, 2011). There is also a lack of evidence to inform EIT programs for Indigenous communities and families in BC (Ball, 2008b; National Collaborating Centre for Aboriginal Health, 2010). This has lead EI therapists in BC to question how to deliver effective services for this population (J. Gordon, personal communication, November 15, 2010). My motivation for this research comes in part from my belief that EIT needs to transform in ways that better address the particular strengths, needs, and contexts of Indigenous families who have children with developmental delays and disabilities.

2.4.3 Addressing Diversity and Complexity

In this sub-section, I provide an overview of the literature that indicates how EI can be responsive to diverse family, geographical, and organizational contexts. Although presented separately here for clarity, I view addressing diversity and complexity, intersectoral collaboration, cultural safety, and trauma- and violence-informed care as inter-related and interdependent aspects of responsive EI. These are explored further in the findings chapters of this dissertation.

Critical early childhood theorists have called for approaches that embrace diversity and complexity so that practices can be more responsive to the realities of

children's lives (Cannella, 1997; Dahlberg et al., 2006; Leslie, 2007). Similarly, health care researchers have highlighted the need to address the complex social challenges and health inequities faced by socio-economically and historically marginalized families and children, by tailoring programs and services to meet their specific experiences and needs rather adopting a 'generic' approach (Browne et al., 2012; Coates, 2008; Lynam, Grant, & Staden, 2012; Lynam et al., 2010; D. Smith et al., 2006). This contrasts with the prescriptive approach to EI being taken up in the US and some parts of Canada, described earlier in this chapter (A. Barlow et al., 2013; Healthy Child Manitoba Office, 2010).

In BC, several urban non-profit organizations have responded to pregnant and parenting mothers who experience multiple forms of marginalization by providing multi-faceted, cross-disciplinary, inter-agency, centre-based and out-reach programs (Lynam et al., 2012; Lynam et al., 2010). These programs have developed an integrated approach that seeks to address social determinants of health, such as housing and nutrition, and provide a range of services, including harm reduction and care for substance abuse, pre and postnatal care, and EI services aimed at keeping newborns and infants healthy and with their mothers (Leslie, 2011; Lynam et al., 2012; Nathoo et al., 2013; Poole, 2007). Similarly in communities across the UK, a comprehensive range of EI, childcare, and maternal health programs are provided by, and coordinated through, hundreds of 'Sure Start Children's Centers'⁴⁰ (All Party Parliamentary Sure Start Group, 2013). Rather than being based on a 'single blueprint', these centers are "multifaceted in the types of

⁴⁰ The diverse way in which these centers have responded to local community contexts has made it challenging to evaluate program outcomes (Belsky, Melhuish, & Barnes, 2008). However, case studies of individual families has shown that the programs are having a positive impact on families' lives (All Party Parliamentary Sure Start Group, 2013).

programs and supports they provide; are locally driven; based on consultation with, and involvement of, parents and local communities, and culturally appropriate” (Belsky et al., 2008, p. 2).

2.4.3.1 Intersectoral Collaboration

In discussing Indigenous peoples’ health, King and Gracey (2009) state that: “fragmentation results in the isolation of symptomatic issues - addiction, suicide, fetal alcohol syndrome, poor housing, and unemployment - followed by the design of stand-alone programmes to try to manage each issue separately” (p. 83). In many parts of Canada, the fragmentation of programs and services for families and children, often requires that families’ complex and multifaceted experiences and needs are dissected and addressed in isolation (McCuaig, 2012). In BC, the fragmented nature of health, child welfare, and early childhood programs for all families with young children “limits user access and causes confusing gaps and duplication in service” (First Call: BC Child and Youth Advocacy Coalition, 2008, p. 11). This fragmentation risks sustaining child health inequities as parents are reluctant or unable to navigate their way through multiple agencies, and adapt their collective needs as a family into uncoordinated silos of service delivery (Leslie, 2007; Lynam et al., 2012).

Extensive evidence shows that addressing the impact of complex and intersecting social determinants on families’ lives requires an intersectoral model of service delivery, in which there is a coordinated continuum of services inclusive of EI, maternal and infant health care, child welfare, and social supports and services (Astuto & Allen, 2009; Coates, 2008; Garner, 2013; Gerlach & Gray Smith, 2009; Grace & Trudgett, 2012; Greenwood & de Leeuw, 2012; Leslie, 2007; Lynam et al., 2010; D. Smith et al., 2007;

World Health Organization, 2013a). This evidence is aligned with repeated calls from Indigenous ECD stakeholders in BC, for more streamlined, less competitive, and long term funding mechanisms that enable the development of a coordinated, comprehensive, and integrated model of service delivery for Indigenous communities, families, and children (Ball, 2005a; First Nations Early Childhood Development Council, 2009, 2011; Gerlach & Gray Smith, 2009). The literature on the over-representation of Indigenous children in the child welfare system in Canada also advocates for governments to support organizations that provide a single point of access to a comprehensive range of programs in order to be responsive to the often socially complex nature of Indigenous families' lives (Hughes, 2013a; Representative for Children and Youth, 2013, 2014). A promising 'hook and hub' model adopted by several Indigenous communities in BC supports a more integrated and intergenerational approach (Ball, 2004, 2005a). In this model an array of community programs and services are located in a 'hub', that may include: health and dental care, childcare, EI, a community kitchen, and meeting rooms (Ball, 2004, 2005a). A hub of community programs and services provides a 'hook' for families to access a wide range of health care services and social supports for both themselves and their children (Ball, 2005a).

2.4.3.2 Cultural Safety

The literature on cultural safety suggests that providing EI in ways that engage Indigenous families, is responsive to the historical and contemporary contexts of their daily lives, and addresses structurally rooted health inequities affecting their children, requires that intervention is provided in ways that are culturally safe (Browne et al., 2012; Health Council of Canada, 2012). Cultural safety has been identified as a critical starting

point for informing relational approaches with Indigenous peoples in health care contexts, because it aims to explicitly address how inequitable power relations, racialization, and other forms of discrimination are discursively enacted through routine health care policies and practices (Brascoupe & Waters, 2009; Browne et al., 2012; Health Council of Canada, 2012). Cultural safety developed from the work of Maori nursing scholar, Ramsden, in response to the inadequacy of cultural sensitivity training to address the multifaceted effects of colonial oppression on the health of Maori people in Aotearoa/New Zealand (Ramsden, 1993, 2005). Rather than focusing on cultural differences, cultural safety aims to reveal and transform the cultural nature of health care (Gerlach, 2012).

As a conceptual and educational framework, cultural safety has been taken up in diverse health care settings and with a variety of population groups as a way of addressing health and health care inequities (J. M. Anderson et al., 2003; Health Council of Canada, 2012; McCall & Pauly, 2012). However, despite a growing interest in how cultural safety can improve early childhood programs and services for Indigenous families and children, there remains a lack of research in this area (Ball, 2010; Gerlach, 2007; Gerlach et al., 2009).

2.4.3.3 Trauma- and Violence-Informed Care

A history of trauma is highly prevalent amongst families and children who experience marginalization (SAMHSA, 2012). As previously discussed, the structural violence of colonization is manifested in, and often continuous with, histories of trauma, mental illness, substance use and IPV amongst Indigenous families (Browne et al., 2011c; Haskell, 2012; Varcoe & Dick, 2008). Pertinent to this dissertation, is the

increasing evidence that links maternal experiences of trauma and chronic stress during pregnancy and early parenting with adverse and potentially long term effects on children's health and development (Monk et al., 2012; SAMHSA, 2012). Despite increasing evidence on the neurological impact of trauma and adversity on children's brain development between conception and age five (Knitzer & Lefkowitz, 2006; Shonkoff, 2010), little is known about how to address trauma and structural violence through EI.

Trauma- and violence-informed care (TVIC) emphasizes “respectful and empowerment practices informed by understanding the pervasiveness and effects of trauma and violence, rather than ‘trauma treatment’, such as psychotherapy” (Browne et al., 2012, p. 7). TVIC recognizes, and is responsive towards, the effects of trauma and interpersonal and structural violence (such as poverty and racialization) on peoples’ health and health care experiences (Browne et al., 2012; Varcoe & Dick, 2008; Wong et al., 2011). From this perspective, interpersonal and structural dimensions of trauma are viewed as being equally significant and mutually constituted.

2.5 Indigenous Early Childhood Programs

In recognizing the critical importance of the early years, many Indigenous leaders, communities, and families are reasserting their roles and rights with respect to what they want for their children (British Columbia Aboriginal Child Care Society, 2014a; First Nations Information Governance Centre, 2012; Greenwood, 2006). In addition, the Truth and Reconciliation Commission (2015) has called on “federal, provincial, territorial, and Aboriginal governments to develop culturally appropriate early childhood education programs for Aboriginal families” (p. 190). Early childhood programs, when they are

anchored in local Indigenous and community cultures, languages, practices, and histories, play a foundational role in children’s cultural identity and health trajectory, and provide a pathway for the collective health and well-being of their communities and Nations (Greenwood, 2006, 2013; Greenwood & de Leeuw, 2012; Greenwood et al., 2007; Greenwood & Jones, 2015; Reading & Wien, 2013; Royal Commission on Aboriginal Peoples, 1996b; Smylie & Adomako, 2009). This requires that programs are embedded within interdependent relational networks involving families, Elders⁴¹, and community members (Greenwood & de Leeuw, 2007). Providing Indigenous children with early childhood programs that are rooted in community is a challenging process for multiple reasons, including: the enormous diversity of Indigenous peoples living in urban contexts (Place, 2012); the effects of colonization on the intergenerational transmission of Indigenous knowledges and cultures (Stout, 2012); the dominance of ‘the sacred Western lens’ in early childhood educational programs (Cannella & Viruru, 2004), and as I discuss later, the constraints of current governance and funding structures.

From an international policy context, Britto and colleagues (2011) state that: “quality is a key feature [of early childhood programs] because when programs of low quality are provided they are unlikely to generate the child and family outcomes intended” (p. 1). In the context of Indigenous programs, high quality early childhood programs are viewed internationally as critical sites for cultural and language revitalization and community rebuilding for Indigenous families and communities (Grace

⁴¹ Elders in Indigenous communities “have always shared their knowledge of language and cultural traditions with children. Today, Elder participation in early childhood programs yields benefits for the children, for the Elders themselves, and for the community as a whole” (British Columbia Aboriginal Child Care Society, 2014b, p. 1).

& Trudgett, 2012; Greenwood, 2005; Greenwood et al., 2007; Guilfoyle, Sims, Sagers, & Hutchins, 2010; Hutchins, Frances, & Sagers, 2009). From a human rights perspective, these programs may also be viewed as important sites for social justice as they provide children with their individual and collective rights to their cultural heritage, language, and identity (United Nations Committee on the Rights of the Child, 2009).

Through a recent province-wide community consultation process, the BC Aboriginal Child Care Society (2014a) determined that:

“High quality in a BC Indigenous early child care and development context means that programs for Indigenous children must be culturally appropriate, reinforce pride in identity, be grounded in an Indigenous world view and spirituality, and include Indigenous knowledge, values, ways of being and ways of caring for young children. Research shows Indigenous early child care and development needs to have sustainable funding, structural supports, and a strong focus on early learning and care to be successful” (p. 2).

To add to this definition, the literature on Indigenous early childhood programs in the BC and Canadian context, also identifies the following as key features for quality programming: community governance and accountability, a broad and holistic view of health and well-being, family, Elder and community involvement, and comprehensive and coordinated programs (Ball & Le Mar, 2011; British Columbia Aboriginal Child Care Society, 2003, 2011; First Nations Early Childhood Development Council, 2009, 2011; Gerlach et al., 2009; Greenwood, 2006; Greenwood & de Leeuw, 2007).

Understanding if and how features of quality Indigenous early childhood programs are manifested in AIDPs is pertinent to the purpose of this research.

2.5.1 Historical and Political Context

In BC and across Canada, Indigenous programs have become an established feature of the early years landscape. This transformation has come through calls from

Indigenous leaders, communities, and families who have long advocated for high quality Indigenous programming and services for their children (Assembly of First Nations, 1995; Blackstock et al., 2006; British Columbia Aboriginal Child Care Society, 2003, 2011; First Nations Early Childhood Development Council, 2011; Greenwood & Perry, 2000; Royal Commission on Aboriginal Peoples, 1996b).

Prior to the early 1990's there were virtually no early childhood programs specifically for Indigenous families and children in Canada (Greenwood & Perry, 2000). A landmark in 1995 was the First Nations/Inuit Child Care Initiative which created 6,000 childcare spaces for children living on reserves in First Nations and Inuit communities (Greenwood et al., 2007). In 1995, the federal government also established the Aboriginal Head Start (AHS) Program for 'Indian, Métis and Inuit children' living in urban centers and large northern communities (British Columbia First Nations Head Start On-reserve Program, nd). This was followed in 1998 by First Nations leadership successfully advocating for First Nations Head Start programs for children living on-reserve (British Columbia First Nations Head Start On-reserve Program, nd).

Over the past 20 years in BC, Indigenous early childhood programs have expanded to every region of the province. This expansion has been shaped by multiple factors including: governance and funding structures, the enormous diversity of First Nations, the particularities of demographic and geographical contexts, and pre-existing resources for families and children. During this period, established province-wide mainstream programs, the Supported Child Development Program and the Infant

Development Program⁴² (IDP), have been used as platforms for launching Indigenous counterpart programs: the Aboriginal Supported Child Development Program⁴³ (ASCDP) and the AIDP, which as the focus of this study, is described in more detail later in this chapter.

Currently, the authority and responsibility for funding, designing, and evaluating Indigenous early childhood programs and services remains primarily with federal and provincial government ministries (Blackstock & Trocmé, 2005; First Nations Early Childhood Development Council, 2009; Webster, 2012). On reserve programs are governed and funded federally whilst off reserve programs are governed and funded provincially. In BC, funding under an ‘Early Childhood Agreement⁴⁴’ aims “to support a wide range of community-based early years programs and services for young children and their families across the province” (Ministry of Children & Family Development, 2013, p. 5). However, there has been and continues to be a lack of transparency, accountability, political will, and funding at the provincial and federal level for Indigenous early childhood programs (British Columbia Aboriginal Child Care Society, 2014a; Issac & Jamieson, 2015). “As a result, the quality of these programs, and

⁴² The Infant Development Program (IDP) was started by a group of parents of infants who had developmental delays and professionals who were involved with service provision to these children in Vancouver in 1972. Their current mandate is to provide “primarily home-based services for infants at risk for and with a developmental delay or disability and their families” (Brynelson, 2004, p. 2)

⁴³ ASCD programs provide “culturally-appropriate support services to children with special needs. Services are provided in childcare centers or home and community environments” (Ministry of Children & Family Development, 2011, p. 29).

⁴⁴ The ‘Early Childhood Agreement’ prioritizes funding for: promoting maternal health, improving parenting and family supports, and strengthening children’s early development, learning, and care (Ministry of Children & Family Development, 2013). Programs and services funded through this agreement are administered by the MCFD⁴⁴ (Ministry of Children & Family Development, 2013).

consequently their effectiveness, may be compromised and access to these programs is severely limited for Aboriginal children in urban areas” (Issac & Jamieson, 2015, p. 178).

A radical and promising shift in the Indigenous early childhood landscape in BC has been the formation of new governance structures including a First Nations Health Council and a First Nations Health Authority (FNHA) (First Nations Health Council, 2013). Federal early childhood programs for Indigenous families and children living on-reserve are among the programs being transferred to the governance of the FNHA. The relationship between the Maternal and Child Health Committee of the FNHA and Indigenous early childhood programs for families living off reserve continues to evolve. The FNHA has indicated that self-governance will result in more culturally enriched early childhood programs and greater flexibility in determining priorities (British Columbia Aboriginal Child Care Society, 2014a).

Self-governance in Indigenous early childhood programs is fundamental to creating the epistemic space and freedom necessary for families, Elders, communities, and Nations to shape the knowledge that they deem as important in raising their children (Blackstock et al., 2006; British Columbia Aboriginal Child Care Society, 2014a; Greenwood & Jones, 2015; Rodríguez de France et al., 2007). The mandate and expectations that accompany state governed policies and funding mechanisms profoundly shape the design, delivery, and capacity of Indigenous early childhood programs, and consequently the experiences of the children they serve (British Columbia Aboriginal Child Care Society, 2014a). For example, attempts by some Indigenous early childhood programs in BC to be responsive to local contexts and social determinants have been

constrained by funding structures and requirements that have ‘school readiness’ as their primary goal (Ball & Le Mar, 2011).

In spite of growing national and international dismay and criticism, structural inequities in governance and funding continue to contribute towards many Indigenous children being denied equitable access to early childhood programs (Ball, 2008b; Blackstock et al., 2006; Canadian UNICEF Committee, 2009; First Nations Child and Family Caring Society of Canada & KAIROS: Canadian Ecumenical Justice Initiatives, 2011; Organization for Economic Co-operation and Development, 2006; Wright, Hiebert-Murphy, & Gosek, 2005). It may therefore be surmised, that although some of the building blocks for quality Indigenous early childhood services and programs in BC are already in place “much construction lies ahead” (First Nations Early Childhood Development Council, 2011, p. 7).

2.6 The Aboriginal Infant Development Program of British Columbia

This research was undertaken in partnership with the Provincial Advisor and Steering Committee of the AIDP, and in the final section of this chapter, I provide an overview of this program. Understanding the socio-historical and organizational contexts of AIDPs, and their successes and challenges, foreshadow the findings in this research.

The AIDP is a well-established EI home-visiting program for Indigenous families with young children from birth to age six who are living on and off reserve communities throughout the province of BC. Unlike centre-based programs that tend to be more child-centered in their programming, AIDP workers visit families in their homes and other community settings and work closely with family members to support them in promoting their children’s health and well-being. AIDP workers frequently use the term ‘family-

centered practice’ to describe their programs. However, it is currently unclear how this is translated into practice. AIDPs can be accessed during pregnancy and continue until a child enters the educational system. For some families, their local AIDP is the ‘first stop’ in a continuum of Indigenous early childhood programs that can include Aboriginal Head Start (AHS) programs once a child is three years old.

2.6.1 Socio-Historical Roots

In the late 1970s a rash of suicides in young adults from the Cowichan Nation on Vancouver Island prompted Elders, and Chief and Council to declare that ‘we have to start with the little ones’ (Office of the Provincial Advisor for Aboriginal Infant Development Programs, 2013). From 1980-1983, a family home-visiting program, the ‘Native Infant Program’ was funded by the Cowichan Nation. This program formed the basis for the launch of an AIDP in 1992 (Office of the Provincial Advisor for Aboriginal Infant Development Programs, 2013). At this time the mainstream IDP had been in existence in BC since 1972 and provided a starting point for the AIDP. Since 1992, AIDPs have had the freedom to evolve and adapt in order to engage communities and families in their programs (Office of the Provincial Advisor for Aboriginal Infant Development Programs, 2005). An historical timeline of AIDPs, and their vision and mission statements are provided in the Appendices. In spite of garnering national⁴⁵ and international attention, AIDPs currently exist only in BC.

⁴⁵ There have been expressions of interest from the James Bay area of Ontario, and Iqaluit in Nunavut (D. Elliott, personal communication, June 2, 2015).

While both IDP and AIDP may be described as grassroots programs, their histories and discourses reflect distinct worldviews about young children and EI. Mainstream IDP is embedded in, and representative of, the dominant ECD discourse described earlier in this chapter. IDP was started in an urban context by “a group of parents of developmentally delayed infants and professionals involved with service provision to these children in Vancouver in 1972” (Brynelsen, 2004, p. 5). The primary purpose of IDPs is to support families to “make optimum use of available services, to enlarge their knowledge of those factors pertinent to overall growth and development of their child, and to learn skills, which will enable them to encourage the development of their child” (Brynelsen, 2004, p. 5). The population served by IDP is described as “children from birth to three years identified as at-risk for developmental delay, developmentally delayed in one or more skill areas, or with a diagnosed disability” (Brynelsen, 2004, p. 6).

2.6.2 AIDP Workers

In a recent online survey of AIDP workers (N=33), the majority of the respondents self-identified as having ‘Aboriginal, First Nations or Métis heritage’ (n=22) (Office of the Provincial Advisor for Aboriginal Infant Development Programs, 2014). The majority of workers have a diploma or certificate in ECE or a degree in ECD or related field (Office of the Provincial Advisor for Aboriginal Infant Development Programs, 2014).

2.6.3 Organizational Structure

The structure of the AIDP, and the various roles within this provincial program, are summarized in Table 1.

Table 1: Structure of the Aboriginal Infant Development Program of British Columbia

AIDP Structure	Role
Provincial AIDP Steering Committee (Includes: Elders, a parent, interdisciplinary Indigenous and non-Indigenous early childhood professionals and an AIDP Regional Advisor.)	Oversees and guides all AIDP practices, policies, and education.
AIDP Provincial Advisor	Coordinates and provides support and educational information to AIDP Regional Advisors and workers throughout the province.
AIDP Regional Advisors (Vancouver Coastal, Fraser, Vancouver Island, Northern, and Interior regions)	Manages and co-ordinate AIDP workers in their regions; co-ordinate with other ECD and child-related programs and services in their region, and often also provide direct services to families and children.
AIDP Workers	Provides direct support and services to families and children in their homes and other community settings.

Since its inception in 1992, AIDP has grown from 2 to 49 programs⁴⁶, and in 2012 over 1,800 children and their families accessed AIDPs in different regions of the

⁴⁶ There is a great variation in the funding and size of programs. A ‘program’ can range from a 0.5 full-time equivalent position up to four or five full-time equivalent positions (D. Elliott, personal communication, June 30, 2015).

province (Office of the Provincial Advisor for Aboriginal Infant Development Programs, 2013). The AIDP regions correlate with the current health regions and programs are provided on and off reserve. Their distribution is summarized in Table 2.

Table 2: Distribution of Aboriginal Infant Development Programs On and Off Reserve

Region:	On Reserve:	Off Reserve:	Total:
Vancouver Island	9	2	11
Vancouver/Coastal	5	3	8
Fraser	1	5	6
Interior	4	10	14
Northern	3	7	10
TOTAL AIDP	22	27	49

Results of a recent online survey of AIDP workers (N=33), indicate that although the majority of programs are located off reserve, many of the workers in these programs provide services to families living on reserve (Office of the Provincial Advisor for Aboriginal Infant Development Programs, 2014) .

2.6.4 Host Organizations

Each AIDP is hosted and administered by a community-based organization, and is often co-located with other family and children services and programs. Host organizations vary within and between regions in terms of their organizational structure, mandate, and programming. The provision of funding for each AIDP is dependent on the host organization agreeing to follow provincial AIDP policies and procedures (Office of

the Provincial Advisor for Aboriginal Infant Development Programs, 2005). Host organizations are responsible for administering a contract for their AIDP, which is renewable annually. The Provincial Advisor of the AIDP states that: “this contract currently emphasizes the importance of workers conducting individual assessments and referrals, completing SIRF⁴⁷ each month, and doing a year-end report. This contract currently does not allow us to be who we are, or who we need to be” (D. Elliott, personal communication June 30, 2015).

Results of a recent survey of AIDP workers (N=33) from across BC, indicated that host organizations are primarily: child and/or family organizations (n= 16), Friendship Centres (n=6) and health centers (n=6) (Office of the Provincial Advisor for Aboriginal Infant Development Programs, 2014). The majority of programs are hosted by an Indigenous organization (n=26) (Office of the Provincial Advisor for Aboriginal Infant Development Programs, 2014). In recent years, an increasing number of programs are hosted in Friendship Centres⁴⁸ (FC), and currently 11 of the 25 FCs in BC administer and host AIDPs. AIDPs for families living in on reserve communities are funded federally, while programs for families living off reserve are funded provincially through

⁴⁷ SIRF refers to a ‘Service Indicator Reporting Framework’ that is used by the MCFD to collect data on each program and was “developed with no community consultation” (D. Elliott, personal communication June 30, 2015). SIRF is discussed in the findings in Chapter Six and the recommendations in Chapter Seven.

⁴⁸ Friendship Centres are non-profit community centers and program/service delivery organizations located in many towns and cities across Canada for Indigenous peoples who live in urban areas. In BC, there are currently 25 Friendship Centers (Wikipedia, 2015).

the MCFD. Currently, AIDPs receive less provincial funding than their mainstream counterpart programs, IDPs⁴⁹ (D. Elliott, personal communication, May 10, 2012).

2.6.5 Program Outcomes

Over the past 10 years AIDP have undertaken their own province-wide on-line surveys to gain community input and feedback on their programs. Feedback from communities has been overwhelmingly positive (Gray Smith & Gerlach, 2012a). Anecdotal evidence suggests that indicators of their programs' success include: decreases in 'family crisis' and children being removed from their homes, increases in families' access of dental and health care services, increases in children's participation in preschool, childcare, or AHS programs, and parents returning to school or re-entering the workforce (D. E. Elliott, personal communication, May 10, 2012).

Challenges identified by the Provincial Advisor include: shortage of trained and experienced AIDP workers, lack of targeted funding for home-visiting programs, perceived overlap of services (including with AHS, IDP and ASCD programs), short-term or one-time only funding and lack of research evidence to support need for sustained and increased funding, and confusion over being a home-visiting EI program (D. E. Elliott, personal communication, May 10, 2012).

2.7 Concluding Comments

This chapter provides insights into the complex and multifaceted nature of health and well-being for Indigenous families and children, and how socio-economic

⁴⁹ There is limited information available on the amount funded by the MCFD for AIDP as compared to the IDP. However, according to the AIDP Provincial Advisor, AIDP workers starting hourly rate is typically \$18, compared to IDP workers at \$22 per hour (D. Elliott, personal communication, May 21, 2015).

determinants, that can affect all families, intersect with determinants, such as colonization that are specific to Indigenous populations (de Leeuw et al., 2015; King & Gracey, 2009). This chapter also illustrates the complex ways in which health inequities affecting Indigenous children are rooted in intersecting structural inequities that have become a seemingly normative part of our society. This is of grave concern, given the increasing evidence that adversity in early childhood ‘can last a life time’ (Bezruchka, 2010).

Quality Indigenous early childhood programs are vital for healthy children, families, and communities. Over the past 20 years AIDPs have become an established part of the early years landscape in BC. There currently remains a lack of evidence of how EI provided by AIDPs influences the health and well-being of Indigenous families and children and are responsive to health inequities affecting children experiencing social disadvantages that stem from broad and multifaceted structural factors.

CHAPTER 3: THEORETICAL PERSPECTIVES

This research required a theoretical framework that had the analytic depth and complexity to generate nuanced understandings of Indigenous families' lived realities, and how an EI home-visiting program influences families and children's health and is responsive to health and social inequities affecting families and children experiencing social disadvantages. In this chapter I make explicit my positionality and epistemology, and the theoretical perspectives that collectively shaped and informed this critical inquiry. I also discuss my rationale for these theoretical choices, and how the distinct features of my theoretical framework converge.

3.1 Positionality

My positionality was 'deeply and unavoidably implicated' in the process of generating knowledge in this inquiry (Sandelowski & Barroso, 2002). The motives, concerns, questions, and humility that I brought to this research flowed from my experiences and relationships with Indigenous Elders, families, children, early childhood colleagues, and leaders as an occupational therapist in a community-based EIT team and as a community researcher over the past 15 years (Gerlach, 2003, 2007; Gerlach & Gray Smith, 2009; Gerlach & Zeidler, 2004; Gray Smith & Gerlach, 2012b). On first entering the rural reserve community in southwestern BC in which I had been invited to work as an occupational therapist in 1998, I knew very little about colonization, how neocolonial processes impacted families and children's daily lives and their health and well-being, or how my routine occupational therapy practices were inadvertently implicated in the micro-politics of power and oppression. My relationships with community members,

Elders, and leaders, that developed over an extended period of time, led to the community's Chief and Council giving their consent for me to undertake research for my Master's degree with family members who were raising children with developmental challenges (Gerlach, 2003). In a research interview, one of the participants whom I had known for several years, shared her fears about a routine home visit I had undertaken as her occupational therapist with a colleague, stating: "I would be scared that you would take them [her children] away because they're not living in the standards of Canadians, somehow you guys would have the power to take them away" (Gerlach, 2003, p. 85). This was a pivotal moment in learning about my positionality.

My ongoing learning about the social locations I occupy in relation to Indigenous peoples, as it is embedded in my community relationships and experiences, have drawn me to critical theoretical perspectives as a means to interrogate my positionality, occupational therapy practices, and research interests in relation to Indigenous families and communities. In taking a critical stance, I view knowledge as being influenced and mediated by socially and historically constituted relations of power and control between individuals, groups, and institutions (Foucault, 1980). A central feature of this inquiry, and consistent with its theoretical framing, has been self-reflexivity to continue to interrogate my position of power and privilege and "how the space that I occupy in relation to, and with Indigenous people, is constituted and shaped irretrievably by historical colonial and neo-colonial practices and processes" (Gerlach, 2015, p. 7). I remained vigilant throughout the course of this study to inadvertently reproducing relations of power and paternalism, which I discuss in more detail in Chapter Four.

My worldviews and perspectives on health and EI are irrevocably shaped and informed by my professional and academic orientation. In recent years, I have been increasingly drawn to critical occupational science scholarship (Angell, 2012; Galvaan, 2012; Kantartzis & Molineux, 2012; Laliberte Rudman, 2013). A critical perspective of peoples' occupational engagement and 'choices' resists and disrupts the neoliberal individualism and reductionism that frequently creeps into occupational therapy practices and discourses (Gerlach, 2015). In the context of working with Indigenous children, for example, a critical occupational science lens draws attention to the ways in which colonial and socio-economic structures create occupational injustices⁵⁰ when they prevent children from participating fully and freely in play as a central occupation of early childhood that is vital to their health and development (Gerlach, Browne, & Suto, 2014a).

Generating and sharing knowledge for the purpose of social change requires a fine balance between analytical scholarship and action-orientated advocacy that is grounded in relational practices (Reimer Kirkham & Anderson, 2010). In this study, I locate myself as an advocate⁵¹ in solidarity *with*⁵² the community research partner (CRP) and research participants with a shared goal of generating knowledge on practical actions to improve the health and well-being of Indigenous families and children in BC. In this role I occupy

⁵⁰ In seeking to understand and address the experiences of people who are unable to participate fully and freely in valued and meaningful occupations because of multiple factors and broader social structures, occupational scientists have been exploring the concept of occupational justice (Durocher et al., 2013; Whiteford, 2011). Occupational injustice occurs when individuals are either prevented from participating in occupations, or have occupations imposed on them that are unlikely to be of benefit (Stadnyk, Townsend, & Wilcock, 2010).

⁵¹ I am defining advocacy as the "active support of an idea or cause etc.; especially the act of pleading or arguing for something" (Canadian Institute of Health Research, 2010, 2012).

⁵² I am in agreement with Marker that the colonial enterprise of "advocating *for* Indigenous communities is a suspiciously ethnocentric and patronizing goal" (2009, p. 370)

a position of ally who is learning *from* and advocating *with* voices that have typically been silenced, rather than speaking on behalf of the ‘Other’ and inadvertently undermining the agency of research participants and partners (Reimer Kirkham & Anderson, 2010). My positionality is therefore not a neutral one, as I strive to balance the dual roles of ‘advocate and analyst’ (Reimer Kirkham & Anderson, 2010).

3.2 Relational Epistemologies

Undertaking this research led me to question my epistemological orientation. Over the years I have frequently used the phrase ‘it all comes down to relationships’ to describe how my work with Indigenous families and children was implicitly grounded in, and shaped by, my experiences of ‘being in relation with’ community (Wilson, 2008). In seeking to explore my ontological⁵³ and epistemological⁵⁴ orientation, I am drawn to two distinct but aligned relational epistemologies: the work of Western educational philosopher Thayer-Bacon (2010) and Cree scholar Wilson (2008).

Thayer-Bacon defines knowledge as:

“something people develop as they have experiences with each other and the world around them. People improve on the ideas that have been developed and passed to them by others. They do so by further developing their own understandings and enlarging their perspectives. With enlarged perspectives, they create new meanings from their experience” (Thayer-Bacon, 2003, p. 9).

In other words, the ‘knower and the known’ cannot be separated. This definition resonates with my habit of circling back and forth between knowledge gained from my

⁵³ Ontology is the study of “the nature of existence, or the nature of reality” (Wilson, 2008, p. 33).

⁵⁴ Epistemology is the study of “the nature of thinking or knowing. It involves the theory of how we come to have knowledge, or how we know that we know something” and “is tied in to ontology, in that what I believe to be ‘real’ is going to impact on the way that I think about that ‘reality’ (Wilson, 2008, p. 33).

lived experiences, observations, interactions, and reflections from being ‘in community’ and my academic theorizing. From this perspective, I am drawn to Thayer-Bacon’s (2003) description of knowledge as ‘knowing’, as it “reminds us that it is a verb always in process, emphasizing knowing’s transactional qualities and not describing ‘it’ as a finalized object or product” (p. 10).

There is immense variability within and between Indigenous peoples and their respective worldviews and philosophies (Battiste, 2008). However, relational epistemologies are often at the core of many Indigenous knowledge systems (Battiste & Henderson, 2000; Castellano, 2000; Greenwood et al., 2015; Little Bear, 2000; Tagalik, 2015; Wilson, 2008). The relational aspect of Indigenous worldviews is conveyed by Greenwood (2005) as follows:

“The foundations of Indigeneity, then, are comprised, in part, of values that privilege interrelationships among the spiritual, the natural and the self; reflect a sacred orientation to place and space; encompass a fluidity of knowledge exchanged between past, present and future, thereby allowing for constant and dynamic knowledge growth and change; and honour language and orality as an important means of knowledge transmission” (p. 554).

In the context of an Indigenous research paradigm, relational ontology and epistemology are inseparable as “an idea cannot be taken out of its relational context and still maintain its shape” (Wilson, 2008, p. 8). Wilson (2008) describes a process of ‘relational accountability’ in which “the methodology needs to be based in community context (be relational) and has to demonstrate respect, reciprocity and responsibility (be accountable as it is put into action)⁵⁵” (p. 99). An integral feature of relational accountability, that is consistent with the theoretical perspectives that inform this study, is

⁵⁵ Parentheses are Wilson’s (2008).

the importance of focusing ‘on the positive’ as an explicit resistance and counter narrative to the plethora of research “done on Indigenous people in the past [which] has focused on epidemiology and ill-health rather than on health” (Wilson, 2008, p. 109). Recognizing and building on individuals’ existing agency and capacity was of central concern in this inquiry, given the historically constituted and deficit-oriented social discourses that persist in relation to Indigenous women and children (Salmon, 2007b; Tait, 2000; van Herk et al., 2011b). I return to Wilson’s (2008) concept of ‘relational accountability’ in discussing my methodology in Chapter Four, and draw on and extend this concept to inform my findings in Chapter Six.

Although it is important to recognize the distinctive nature of Thayer-Bacon’s (2003) and Wilson’s (2008) respective approaches to relationality, they converge in their belief that knowledge cannot be separated from the relational contexts in which it emerges. Drawing on these perspectives of relationality provided a language and framing for my epistemological stance that I lacked on entering this research. Together they provided a complementary relational orientation, which was congruent with my research purpose and questions, theoretical perspectives, and methodology. In using the term ‘relational’ in this dissertation, I am referring to socio-relational understandings of health and well-being in which ‘knowing’ is inseparable from the temporal and contextually-embedded experiences and relationships through which it evolves. Also, that a relational perspective of health encompasses socio-emotional, cultural, and spiritual dimensions, and historical, socio-cultural, and economic contextual factors. This appreciation of the contextually embedded nature of knowledge has the potential to provoke complex understandings of children’s health and resist decontextualized discourses in which child

health concerns can become problematized as parental lifestyle behaviors or choices. Relational understandings of health have started to infiltrate and influence the provision of health care for Indigenous and non-Indigenous adult populations (J. K. Barlow, Reading, & Akan, 2008; Browne et al., 2012; Hartrick Doane & Varcoe, 2015; Hovey, Delormier, & McComber, 2014). Evidence suggests that a socio-relational understanding of Indigenous peoples' health, as it takes into effect the historical and ongoing effects of colonization, has the potential to inform new approaches to health promotion for this population (Hovey et al., 2014).

A relational epistemology is well aligned with the critical theoretical perspectives of postcolonial feminism and Indigenous feminism that informed and shaped this research, as they share a socio-relational orientation to knowledge construction for the explicit purpose of promoting social change and justice (Hartrick Doane & Varcoe, 2015; Howell, 2013). These theoretical perspectives are discussed in the following section.

3.3 Postcolonialism *and* Feminism: 'Exploring Intersections in Context'⁵⁶

My draw to postcolonial feminist theorizing is its potential to foreground and challenge the differential ways in which Indigenous women and children's everyday lives, opportunities, health, and well-being are shaped by a complex interplay of multifaceted macro and micro-level historical, socio-economic, and political structures and contexts (J. M. Anderson, 2002). Consistent with the purpose of this research, a postcolonial feminist perspective "challenges the idea of their being a universal

⁵⁶ This subtitle draws directly on the work of nursing scholar Anderson (2004), who has played a central role in exploring the potential of converging postcolonial and Black feminist theorizing in order to promote social justice and health equity.

standpoint on knowledge development” and centers the perspectives of people who have been historically marginalized in the production of knowledge with an explicit agenda of promoting social change (J. M. Anderson, 2002, p. 8).

In the context of critical health research, evidence indicates that employing a postcolonial feminist lens generates a greater understanding of how health inequities are socially determined and structurally rooted in histories of colonization and ongoing neocolonial⁵⁷ structures, practices, and discourses (J. M. Anderson, 2002; Browne, Smye, & Varcoe, 2007a; Khan et al., 2007; Reimer Kirkham & Anderson, 2010). In addition, postcolonial feminist nursing scholars contend that framing health research from this theoretical vantage point has the potential to inform responsive and innovative forms of health care that are better tailored to meet the intersecting needs of individuals and population groups who experience health inequities (Browne et al., 2011a; Browne et al., 2012).

In the following section, I provide a brief overview and critique of postcolonialism. This is followed by an overview of the key tenets of a theoretical perspective that integrates postcolonialism *and* feminism.

⁵⁷ Neocolonialism literally means “new forms of colonial ideology embedded in institutional policies and practices” (Browne & Smye, 2002, p. 30). While less overt than historical forms of colonial practices, neocolonial policies, discourses, and practices may be more insidious and challenging to recognize and resist (Ashcroft et al., 2007).

3.3.1 Postcolonial Theoretical Perspectives

Postcolonial theories⁵⁸ defy a singular definition but are united by a social, political, and moral critique of the history and legacy of colonialism and the manifestations of neocolonialism in the contemporary context (Said, 1978; Young, 2001). Rather than referring to a historical period, postcolonial theorizing creates a critical intellectual space in which past and present colonial processes, discourses, and practices are called into question (Said, 1978). Gandhi (1998) describes postcolonialism as “revisiting, remembering, and crucially interrogating the colonial past” and the ‘colonial aftermath’ (p. 4). Western postcolonial theories have evolved from diverse disciplinary perspectives⁵⁹, and as Dutton, Gandhi, and Seth (1999) highlight, the “tools of postcolonialism get amended and reshaped according to the disciplinary contexts and the purposes for which they are used” (p. 124).

Postcolonial Indigenous knowledge, as a related but distinct endeavor, emerged “from the inability of Eurocentric theory to deal with the complexities of colonialism and its assumptions” (Battiste, 2000a, p. xix). Postcolonial Indigenous scholars call for more complex and transformative strategies to fully comprehend and address Indigenous peoples’ differential circumstances and experiences related to multifaceted forms of colonization, marginalization, and oppression (Battiste, 2000b; Duran & Duran, 2000; Youngblood Henderson, 2000). As noted by Mi’kmaq scholar Battiste (2000a),

⁵⁸ The ‘post’ in postcolonial does not imply that we have moved beyond inequitable social and power relations; rather that new forms of inequities continue to emerge (Ashcroft, Griffiths, & Tiffin, 2007).

⁵⁹ Postcolonial scholarship has evolved through diverse disciplines including cultural studies, political science, literary criticism, and sociology, and includes influential writers such as Ahmad (1993); Bhabha (1994); Gandhi (1998); Hall (1997); Said (1978); Spivak (1994), and Young (2001).

“Indigenous thinkers use the term ‘postcolonial’ to describe a symbolic strategy for shaping a desirable future, not an existing reality” (p. xix).

Postcolonial theoretical perspectives are salient to this dissertation for a number of reasons. As evident in Chapter Two, historical and ongoing colonial practices, policies, and racializing discourses continue to influence the everyday lives, health, wellbeing, and life opportunities of many Indigenous women and children. In addition, the grand narrative and ‘sacred Western lens’ of prevailing knowledge on early childhood (Cannella & Viruru, 2004) has effectively marginalized Indigenous knowledges and perspectives on raising healthy children (Niles et al., 2008; Smylie & Adomako, 2009). The central tenets of postcolonial theorizing that are pertinent to this dissertation are provided in a brief overview in the following section.

As noted by Indigenous scholar, Little Bear (2000): “one of the problems with colonialism is that it tries to maintain a singular social order by means of force and law, suppressing the diversity of human worldviews” (p. 77). Drawing on Foucault’s notion of discourse, Said⁶⁰ (1978) analyzed, detailed, and challenged a politically motivated colonial discourse through which the West socially constructed the ‘Orient’ as the inferior ‘Other’⁶¹ in order to redefine and maintain ‘positional superiority’. As a theoretical lens, postcolonial perspectives expose and contest the complex process by which a dominant social group privileges its own norms and values by marginalizing and excluding social groups with less power (Gandhi, 1998; Said, 1978). From this

⁶⁰ Said’s text ‘Orientalism’ (1978) is widely cited as being a central catalyst and reference point in the emergence of postcolonialism.

⁶¹ ‘Other’ is written with an initial capital “to denote a specific category and space to which ‘non-western’ people, constructed as inferior through the process of racialization and cultural essentialism, have been assigned” (J. M. Anderson, 2002, p. 8).

perspective, hegemonic worldviews, whereby a dominant group's ideologies, theories, and vision of reality are presented as universal, prevail as a consequence of power, rather than their intrinsic superiority or inherent 'universal truth', and become internalized in society as reality (Gramsci, 1978). As discussed in Chapter Two, this form of 'civilized oppression' in early childhood discourse (Viruru, 2005) has left little space for critique (Soto, 2000; Soto & Swadener, 2002), and represents a disservice to both scientific inquiry and the interests of Indigenous children (Niles et al., 2008). A postcolonial perspective challenges the assumption of a universal truth (J. M. Anderson, 2002). As critical early childhood theorists Viruru and Cannella (2006) contend:

“[despite] a conflict-ridden status, postcolonial theory represents vantage points that challenge the center of Western thought and cannot be ignored. . . . Despite the complexities surrounding definition and continued ties to Western institutions like academia, postcolonial theory offers a way to seek new possibilities and to resist forms of control, no matter how hidden or subtle” (Viruru & Cannella, p. 176).

A postcolonial perspective also provides 'a window for understanding' and contesting how race and culture continue to be constructed in ways that reproduce and sustain colonial oppression (J. M. Anderson, 2002). As Anderson and colleagues (2003) note: “Thus race, used as a marker of physical characteristics, and visible appearances, becomes conflated with culture, with certain groups being seen as the inferior, uncivilized Other, whose cultural traits are inherently linked to their physical appearances” (p. 200). As discussed earlier, the racialization and marginalization of Indigenous women and children, particularly in our health care and child welfare systems, continues to reinforce longstanding patterns of oppression and injustice that are highly relevant to this dissertation.

3.3.2 Postcolonial Feminist Theoretical Perspectives

Postcolonial theories have been critiqued by feminist scholars for failing to address the gendered and classed nature of colonization and oppression, and for being preoccupied with categories of difference based on essentializing notions of race, ethnicity, and culture (Gandhi, 2007; Mohanty, 2003; Narayan & Harding, 2000). In recognition of the limitations of postcolonial theorizing, and in response to a call for complex analyses of how gender, racialization, and socio-economic status intersect with historical positioning to create and sustain social injustices and health inequities among certain populations, nursing scholars have contributed to a growing body of postcolonial feminist scholarship (J. M. Anderson, 2004; Browne et al., 2007a; Reimer Kirkham, Baumbusch, Schultz, & Anderson, 2007). This scholarship integrates concepts from critical, feminist, postcolonial, and intersectional theories.

The emergence of postcolonial feminist scholarship has been strongly influenced by Black (Collins, 2009; Crenshaw, 1989, 1991; hooks, 2000) and South Asian (Mohanty, 2003; Narayan, 2000) feminist scholars and activists. These scholars share a concern that the use of 'women' as a fixed category of analysis, has obscured the complex and changing lived realities of women's lives, their historical, geographical, and social contexts, and their capacity for resistance and agency.

Black feminist scholars have called for a complex analysis of women's lives by embracing a paradigm of race, class, and gender as intersecting systems of oppression that re-conceptualizes the social relations of domination and resistance (Collins, 2009; Crenshaw, 1989). The concept of intersectionality is a central and distinguishing feature of Black feminist scholarship. This concept has been attributed to Crenshaw (1989), a

Black critical legal race scholar who challenged that race and gender could not be treated as mutually exclusive categories of discrimination and analysis. Intersectionality has since evolved through Black activists and feminists, postcolonial, queer, and Indigenous scholarship to contest the assumption that ‘women’ as a fixed category of analysis constitutes a homogenous group (Bunjun, 2010; Collins, 2009; Crenshaw, 1989; van Herk, Smith, & Andrew, 2011a). Intersectionality is therefore concerned with:

“simultaneous intersections between aspects of social difference and identity (as related to meanings of race/ethnicity, Indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion) and forms of systemic oppression (racism, classism, sexism, ableism, homophobia) at macro and micro levels in ways that are complex and interdependent (Dhamoon & Hankivsky, 2011, p. 16).

According to Collins (2014), relationality is central to intersectionality as this form of inquiry and action aims to critique, challenge, and dismantle how systems of power are interconnected. From an intersectionality perspective, injustices such as health and social inequities are never the result of single, discrete factors. “Rather, they are the outcome of intersections of different social locations, power relations and experience” (Hankivsky, 2014, p. 2). Intersectionality is increasingly being taken up by human rights activists, government policy stakeholders, community organizers, and researchers to interrogate and address social injustices and health inequities (Hankivsky, de Leeuw, Lee, Bilkis, & Khanlou, 2011).

3.4 Indigenous Feminist Theoretical Perspectives

In recent years Indigenous women writers, scholars, and activists have advocated for critical feminist theorizing to more fully understand and address how Indigenous women’s human rights and well-being are constrained by their individual and collective

experiences of intersecting forms of oppression, including patriarchy, racism, gender discrimination, and socio-economic marginalization (K. Anderson, 2000, 2010; Green, 2007; Huhndorf & Suzack, 2010; Kuokkanen, 2007; LaRocque, 2007, 2009; St Denis, 2007). As a critical theoretical perspective, Indigenous feminism may be perceived as intersectional in nature as this viewpoint foregrounds “how both racism and sexism fuse when brought to bear on Indigenous women” (Green, 2007, p. 23). Indigenous feminist scholarship has also highlighted how systemic forms of oppression operate in and through social policies, practices, and structures (Kuokkanen, 2007).

Indigenous feminist theorizing calls for Indigenous women’s ‘words, perspectives and insights’ (Anderson, 2000) to become central to collective political and social engagement and action to examine, confront, and transform women’s lived experiences of patriarchy and colonization (Huhndorf & Suzack, 2010; Kuokkanen, 2007; LaRocque, 2007). Indigenous feminism has prompted contentious political, cultural, and scholarly debates (A. Smith, 2009; Suzack, Huhndorf, Perreault, & Barman, 2010). This theorizing has been dismissed by some Indigenous scholars as lacking in relevancy and meaning for Indigenous women (Monture-Angus, 1995). However, a small but growing number of Indigenous feminists, who resist a single or unified definition of Indigenous feminism, are carefully and specifically formulating their own ideologies on a feminist inquiry that foregrounds the commonalities and particularities of Indigenous women’s life experiences and circumstances (Huhndorf & Suzack, 2010).

Indigenous feminism must be shaped and informed by Indigenous women. However, as Huhndorf and Suzack (2010) contend, promoting social change and justice for Indigenous women requires “the engagement, contributions, and support of

Indigenous men and non-Indigenous men and women” (p. 4). As this study progressed, my relationship with the theoretical perspectives that framed it evolved. My earlier readings on Indigenous feminism led me to question if, and how, I could draw on this scholarship for this dissertation. Soon after starting data collection however, the perspectives and writings of several Indigenous feminist scholars resonated with me as Indigenous caregivers and Elders shared their experiences and histories.

In particular, I was drawn to the work of Cree Métis scholar Anderson (2000) and Plains Cree Métis scholar LaRocque (2009). Anderson’s (2000) work draws attention to how colonial discourses, practices, and structures sought to dismantle the status of Indigenous women and simultaneously construct “a negative Native female identity” (p. 98). Central to Anderson’s (2000) writing is the question of how Indigenous women “maintain their power, in spite of oppression” (p. 15). She proposes that “Native women engage in a process of self-definition that includes four steps: resist, reclaim, construct and act” that are inextricably embedded within, and linked to, the current, historical and future contexts of women’s lives (K. Anderson, 2000, p. 15). Anderson’s theorizing provided an analytical framing and language as I sought to generate a greater understanding of how EI supported women in resisting ‘negative definitions of being’ and ‘reclaiming’ their agency as Indigenous women and mothers (K. Anderson, 2000).

In reflecting on cultural continuity in the context of families and EI programs that were based primarily in urban settings, I was drawn to the scholarship of LaRocque (2009). LaRocque’s (2009) theorizing provoked a nuanced analytical framing of culture in the context of EI programs, as I considered the relationship between women’s agency, identity, and cultural continuity in urban contexts. LaRocque (2009) emphasizes how

Indigenous women's 'cultural tenacity' has endured "in the face of cultural and legislated assaults" through the "fur-trade era, even through the residential school era, and onto the mid-1900s and now modern times" (p. 154). However, LaRocque (2009) also asks: "What does cultural continuity look like, especially when, for example, the majority of my generation left home and built our lives around very different economic, material, and cultural environments?" (p. 162). In building on the work of Métis scholar St. Denis (2004, 2007), LaRocque (2014) cautions against discourses in which 'culture and tradition', particularly as they are related to the past, are the sole signifiers of 'being Indigenous'. LaRocque's theorizing reminded me of the risks of perceiving visible manifestations of traditional cultural activities, such as drumming and beading, as the sole distinguishing feature of 'Indigenous' early childhood programs.

As outlined in this chapter, postcolonial feminism and Indigenous feminism have distinct epistemological roots. I propose, however, that these distinct perspectives overlap and complement each other to provide a broad contextualized theoretical framework. When employed together, postcolonial feminism and Indigenous feminism provided a comprehensive viewpoint for understanding how gender, as it intersects with socio-economic status, racialization, and historical positioning perpetuate relations and hierarchies of colonial power that operate through social policies and practices to create and sustain social injustices and health inequities for Indigenous women and their children (Browne et al., 2007a; Kuokkanen, 2007). Together postcolonial feminism and Indigenous feminism foreground women's agency and resistance (K. Anderson, 2000; Collins, 2009), and the contextual, intersectional, and praxis-oriented nature of knowledge production (J. M. Anderson et al., 2009; St Denis, 2007). Applying this

theoretical lens also provoked and informed a critical analysis of taken-for-granted assumptions, discourses, and practices about early childhood and intervention. This theoretical framing was consistent with a call from early childhood scholars to draw on critical and feminist theories in order to better understand the complex realities of children's and families' lives (Niles et al., 2008; Soto & Swadener, 2002), and to broaden and deepen the 'early years discourse' in Canada (Pence & Pacini-Ketchabaw, 2008). To the best of my knowledge, this is the first study on EI for Indigenous families and children to employ postcolonial feminism *and* Indigenous feminism as a theoretical framework.

3.5 Concluding Comments

This inquiry was grounded in a relational epistemology and informed from the distinct but overlapping perspectives of postcolonial feminism and Indigenous feminism. This broad theoretical framework created an intellectual space for generating complex, contextualized, and nuanced knowledge pertinent to the research questions guiding this study. Integral to enacting this theoretical framework was an ongoing process of self-reflexivity, which I discuss further in Chapter Four.

CHAPTER 4: RESEARCH DESIGN AND IMPLEMENTATION

To meet the objectives of this critical inquiry the design and implementation of this research was grounded in a relational epistemology, situated within a theoretical framework of postcolonial feminism and Indigenous feminism, and utilized decolonizing methodologies. An overview of decolonizing methodologies is provided at the start of this chapter. The central principles of this method of inquiry are subsequently interwoven throughout the following sections of this chapter that describe: the research design, methods for generating and analyzing data, scientific rigor, and knowledge translation and exchange (KTE). There is a section towards the end of this chapter on ethical considerations, however these are considered integral to the entire research process and the methodological approaches discussed throughout this chapter.

4.1 A Critical Decolonizing Framework

Decolonizing methodologies constitute a distinct philosophical orientation to research that has developed in response to: (a) the historical context in which Indigenous peoples have been over-researched (Tuhiwai Smith, 2012); (b) Indigenous scholars' resistance to the imposition of hegemonic Western research theories and practices (Bishop, 2005; Chilisa, 2012; Mutua & Swadener, 2004); (c) the commodification of Indigenous knowledges (Battiste & Henderson, 2000; McGuire, 2010), and (d) the failure of research to benefit Indigenous peoples (Tuhiwai Smith, 2012). Decolonizing methodologies are centered on the process of revealing, resisting, and dismantling the colonizing potential of Western research practices, including “the deep underlying structures and taken-for-granted ways of organizing, conducting, and disseminating

research and knowledge” (Tuhiwai Smith, 2005, p. 88). This scholarship continues to evolve as Indigenous scholars explore and develop decolonizing research methodologies by affirming and implementing Indigenous epistemologies (Battiste, 2000b; Bishop, 2005; Chilisa, 2012; Kovach, 2009; Tuhiwai Smith, 2005). Non-Indigenous political and intellectual allies are also enacting decolonizing methodologies as a philosophical framework for resisting and redressing the colonizing potential of research; “making Western systems of knowledge the object of critique and inquiry” (Denzin, Lincoln, & Smith, 2008, p. 6), particularly when research involves or affects Indigenous peoples (Bartlett, Iwasaki, Gottlieb, Hall, & Mannell, 2007; Stanton, 2014; Vannini & Gladue, 2008).

A central underpinning of this methodological orientation is that it draws attention to and contests “what counts as valid knowledge and the processes by which one gets to claim knowledge” (Reyes Cruz, 2008, p. 653). Implicit in this methodology is a fundamental shift to learning *from* Indigenous peoples rather than *about* them (Marker, 2009), and an activist agenda of working towards social justice, self-determination, and emancipation (Chilisa, 2012; Diversi & Moreira, 2012; Swadener & Mutua, 2008). From this perspective, research must be centered on, and advance, community-identified priorities and develop knowledge that is useful and beneficial to Indigenous individuals and communities (Ball & Janyst, 2008; Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council, 2014). This methodology is consistent with the purpose and objectives of this research, a relational epistemology, and the theoretical perspectives that informed this study.

As a method of inquiry, rather than a single agreed-upon set of guidelines or specific research methods, decolonizing methodologies provide a critical, ethical, and relational framework underpinned by an inter-related set of concerns, motives, and guiding principles that are brought to the research process (Swadener & Mutua, 2008). In the following sections of this chapter, I describe how I mindfully worked towards integrating and enacting the philosophical underpinnings of this method of inquiry in the design and implementation of this research.

4.2 ‘Researching Together Differently⁶²’: A Community Research Partnership

Decolonizing methodologies support the inherent right of Indigenous peoples to participate as principals or partners in research that generates knowledge affecting their lives and well-being (Brandt-Castellano, 2004). Soto and Swadener (2002) note that: “Gaining insights from collaborative research on children’s daily lived realities can guide the field to critically examine long held practices and establish equity and social justice as paramount aims” (p. 54). The need and focus for this study was developed in collaboration with a community research partner (CRP), the Provincial Coordinator and Steering Committee of the AIDP in BC. As a central methodological underpinning, mutually respectful and transparent academic and community research partnerships, that are in place before the development of a formal research proposal promote: (a) community collaboration and dialogue (Adelson, 2005); (b) research that is more relevant, meaningful, and beneficial for the community (Bartlett et al., 2007; Bishop,

⁶² This phrase draws directly on a paper by Fleras (2004).

2005; Chilisa, 2012), and (c) ethical and high quality research involving Indigenous peoples (Canadian Institutes of Health Research et al., 2014; Kovach, 2009).

The research design, methods of data collection and how I conducted myself in the research process were fundamentally shaped by my experiences as an occupational therapist who had worked in First Nations communities for many years prior to this dissertation study. A relationship of familiarity and mutual trust and respect between the CRP and myself, as the primary researcher, had also developed over many years through my relationships and work within the Indigenous ECD community in BC prior to starting this research. Our relationship provided a strong foundation for my ethical engagement in exploring, planning, and undertaking this research, in which I was ‘relationally accountable (Wilson, 2008) to community, academia, and myself. In a relational ‘ethical space of engagement’ (Ermine, 2007), the CRP and myself sought to move beyond the historical exploitive nature of research *on* Indigenous peoples and work towards a shared agenda of research that could benefit Indigenous families and children (Ball & Janyst, 2008; Browne et al., 2005; Jones & Jenkins, 2008; Marker, 2009). This required an ongoing dialogue with the CRP, which started 18 months before data collection commenced, and continued throughout the entire course of the research. In this dialogue, we explored our assumptions and understandings and addressed various issues and dilemmas as they arose. The AIDP leadership signed a memorandum of understanding, which outlined our partnership on this study (Appendix C). The research was officially announced at the AIDP annual conference in June 2013 and was subsequently posted on their website.

4.3 Research Design

“Research questions that attempt to answer *how* or *why* a process or phenomenon occurs within complex contexts, where variables are difficult to control and measure, are particularly well suited to qualitative methods of investigation” (Trainor & Graue, 2014, p. 268). The research design and methods employed in this study needed to elicit multiple perspectives and analytical insights into: (a) *how* Indigenous families and children’s health and well-being were influenced by social and structural factors, and (b) *how* EI programs influenced family and children’s health and well-being and fostered child health equity. A qualitative design that generated knowledge and perspectives from caregivers who accessed AIDPs, and AIDP workers, Elders, and administrative leaders involved in these programs best met these requirements. The research design and methods were informed by, and aligned with the Royal Commission on Aboriginal Peoples guidelines on conducting research involving Indigenous people; the principles of OCAP (ownership, control, access, possession), and the Tri-Council Policy Statement on ‘Ethical Conduct for Research Involving Humans’ that includes guidelines for research involving Indigenous peoples in Canada (Canadian Institutes of Health Research et al., 2014).

4.3.1 Purposeful Sampling

Research participants and sites were chosen according to the purpose of this inquiry (Creswell, 2013). Also in alignment with the theoretical and methodological framing of this research, the purposeful sampling of Indigenous caregivers, Elders, AIDP workers, and administrative leaders of host organizations was viewed as central to

knowledge production. In this research, the sample of participants (by group) consisted of: AIDP workers (n=18); Indigenous caregivers (n=10); Elders involved in AIDPs (n=4), and administrative leaders of urban organizations that hosted AIDPs (n=3) for a total of 35 ($N = 35$) participants. The diversity and number of participants was sufficient to generate knowledge on specific and shared experiences and perspectives relevant to the questions posed by this study (Creswell, 2013). The inclusion criteria are summarized in Table 3.

Table 3: Inclusion Criteria for Participants

Research Participants	Primary Inclusion Criteria
1. AIDP workers	(a) Employed by host organization as an AIDP worker. (b) Minimum of 4 years AIDP experience.
2. Indigenous caregivers	(a) Currently receiving, or have received, AIDP services. (b) Self-identify as an Indigenous person*. (c) Emancipated youth ⁶³ or adult. [*Non-Indigenous foster caregivers were excluded]
3. Elders	(a) Experience with AIDP (for example: role on AIDP steering committee or local advisory capacity with an AIDP).
4. Administrative leaders	(a) Administrative leader of an organization that hosts an AIDP. (b) Minimum of 2 years of experience in current position.

⁶³ Emancipated youth are under 18 years of age but are living independent of their caregivers.

4.3.2 Research Settings

To address the research question of how AIDPs respond to, and are shaped by, diverse geographical and organizational contexts, the participants in this study were from seven different AIDPs that were located in diverse organizational contexts and regions of the province. In seeking to balance the collection of data from different regions of the province, and in view of my positionality as a non-Indigenous researcher undertaking doctoral research, recruitment and data collection were not undertaken in on-reserve First Nations communities. Rather, all of the AIDPs in this study were based in urban centers of varying sizes and locations in the Vancouver Coastal, Vancouver Island, Interior, and Northern regions of BC. Although urban-based, these programs often provided outreach services to surrounding on-reserve and rural communities.

During data collection, I visited three of these AIDPs that were hosted by, and located within, Indigenous and non-Indigenous community-based multi-service organizations. These organizations were of varying size, with the number of people they served each year ranging from 15,000 to 200,000. They were located in three urban centers in the Vancouver Coastal, Vancouver Island, and Northern regions of BC, in which the population of Indigenous peoples ranged from 1.5% to 12.8% of the total population compared to a provincial average of 5.4% (Statistics Canada, 2014).

4.3.3 Recruitment of Participants

An informational brochure⁶⁴ was developed in collaboration with the CRP and used to generate interest in the study. I sought advice from the CRP on the appropriate and respectful protocol and recognition of all participants. A thank-you card containing an honorarium of \$50 for Elders and \$25 for caregivers was provided prior to each interview in recognition of participants' time, energy, and intellectual work. As the AIDP workers and administrative leaders agreed to be interviewed during their working hours, I thanked these participants with a personal email.

A priority in the recruitment process was to employ strategies that respected potential participants' freedom to choose to not seek out further information and their rights to privacy and confidentiality (Canadian Institutes of Health Research et al., 2014). The CRP distributed an email announcement and invitation⁶⁵ to participate in the study, along with an electronic copy of the brochure, to all AIDP workers, Elders, and administrative leaders who met the inclusion criteria. The CRP did not know which individuals contacted me or agreed to participate. I responded to potential participants directly by phone and/or email to provide further details of the study including the consent process. This recruitment strategy, which may have been aided by many AIDP workers having knowledge of my previous work, proved effective at generating the sample population for these participant groups.

⁶⁴ The brochure (see Appendix D) included information on: the purpose of the study; what was involved in participating; how identity and privacy were protected, and contact information for the UBC Office of Research Services and myself.

⁶⁵ The email informed potential participants about the study and the inclusion criteria, and asked them to contact me directly to discuss the study in more detail and/or to explore their interest in participating.

A primary ethical concern in recruiting caregivers was ensuring that they did not feel obligated to participate in this study as a result of their relationship with their AIDP workers. To address this concern, I mailed information brochures to AIDP workers who had expressed an interest in supporting and/or participating in the study, with a request to leave them in the waiting rooms or communal areas of their programs and host organizations. Workers were also requested to distribute brochures to *all* caregivers during group programs and to avoid targeting specific individuals. I emailed these workers a verbal script (Appendix E) to follow when they handed out the information brochure during their group programs. For caregivers who expressed an interest in the study, AIDP workers provided my telephone, text, and email contact information or, with a caregiver's verbal permission, passed along their contact information to me.

Following interviews with several caregivers at one AIDP, I was invited to attend their group program so that more caregivers had an opportunity to meet me and find out more information about the study. This visit resulted in several caregivers and Elders agreeing to participate. Early on in data collection, an AIDP worker suggested that offering caregivers, who knew each other through their involvement in the same AIDP, the option of doing interviews together would be a helpful recruitment strategy. As a result, the option of small group interviews was integrated into the research design⁶⁶.

4.3.4 Consent Process

When interest in participating was expressed, I arranged with each participant a mutually agreed upon time and location to conduct the interview that was convenient and

⁶⁶ The Behavioural Research Ethics Board at UBC approved undertaking interviews in small groups through an amendment to my original ethics application.

private. To promote informed and voluntary consent, the CRP and my doctoral supervisors were involved in the development of the consent form to ensure that it was inclusive, respectful, and used plain language (Canadian Institutes of Health Research et al., 2014). The CRP was not involved, however, in any part of the consent process. During a verbal explanation of the consent process, prior to starting the interview, each participant was informed of her or his rights to: (a) refuse to participate; (b) refuse to answer a question; (c) stop the interview at any time; (d) ask me any questions related to the research during or following an interview, and (e) withdraw from the research (Canadian Institutes of Health Research et al., 2014). At this time, each participant indicated on the consent form whether they would like to receive a copy of their transcript and a summary of the research⁶⁷. Following signed consent and prior to starting the interview, caregivers and AIDP workers were asked to self-complete a socio-demographic form.

4.4 Overview of Participants

Consistent with the theoretical framing of this study, a limited amount of socio-demographic information was collected on the primary research participants: AIDP workers and caregivers⁶⁸. Socio-demographic variables were chosen because of their relevance to the research questions and their applicability to health outcomes. This data was collated and summarized using Excel[®] to help contextualize the specificities and complexities of these participants' individual social locations and experiences. This

⁶⁷ The majority of participants (n=23) chose to receive a hard and/or email copy of their transcript and were asked to contact me if they wished to make any changes or additions. The majority of participants (n=33) also requested a copy of the final summary report on the study.

⁶⁸ Summaries of the socio-demographic information on Indigenous caregivers and AIDP workers are in appendices F and G respectively.

information was kept strictly confidential and stored separately from interview transcripts.

4.4.1 Indigenous Caregivers

All of the caregivers (n=10) in this study self-identified as having Indigenous ancestry and the majority were born or raised in BC (n=8). The majority of caregivers were women (n=9) and mothers⁶⁹ (n=8). At the time of the study, the average age of the caregivers was 36 years⁷⁰ (ages ranged from 30 to 48 years). Most caregivers (n=8) were living with their children in rented apartments, and two were living in supported housing. All of the caregivers had moved away from their home communities and were living in urban centers. It was unclear if or how caregivers maintained a connection with their home communities. Educational levels and employment status varied widely: five caregivers had achieved between a grade 8 to 10 education; three caregivers had a grade 12 education, and two caregivers had a university education. Three of the caregivers had part-time employment; two were in school; one had voluntary employment, and four had no form of employment. The majority of the women (n=7) were raising their children as single mothers. One mother, and the one father in this study were in common-law-relationships. Caregivers had between one to eight children under 18-years old, with the average number of dependent age children being three. The majority of the caregivers (n=9) had experienced having children in their teenage years or young adult lives who were subsequently removed from their care temporarily or permanently. At the time of

⁶⁹ One caregiver who participated in a small group interview was an auntie.

⁷⁰ According to the CRP the age of caregivers accessing AIDPs can range from 16-year old teenage mothers to 65-year-old grandmothers or foster mothers.

this study, half of the caregivers had children who were being raised by other family members or were in the foster care system. The average length of time caregivers had been involved with their AIDP was three years.

4.4.2 Aboriginal Infant Development Program (AIDP) Workers

All of the AIDP workers (n=18) were female, with an average age of 45 years (ages ranged from 30 to 58 years). Ten of the workers had varied European ancestry and eight had Indigenous ancestry. Workers' educational backgrounds varied: six had early childhood education diplomas, nine had bachelor degrees, and three had master's degrees. Workers were very experienced with an average of 20 years (ranging from four to 35 years) in Indigenous and mainstream early childhood programs. The average number of years with AIDP was seven years (ranging from four to 20 years). Fourteen of the workers were working full-time for AIDP with an average caseload of 18 families (ranging from 15 to 28). Several of the workers also had experience of being AIDP regional advisors, which afforded them a more regional perspective that was highly relevant to this study.

4.4.3 Elders and Administrative Leaders

A limited amount of socio-demographic information on Elders and administrative leaders was generated through their interviews. The three female Elders and one male Elder who participated in this study had been involved with their AIDP for several years. The four Elders were all grandparents and were living in urban centers in three different regions of the province. The three female administrative leaders who participated in this study were based in Indigenous and mainstream host organizations in three different

regions of BC, and had many years of experience in relation to programs for women, families, and children. One of the administrative leaders had Indigenous ancestry.

4.5 Data Collection Methods and Procedures

In-depth and semi-structured interviews, as the primary method of data collection, were used for their potential to generate knowledge and insights in terms of depth and complexity that could not have been collected through quantitative methods. This method of data collection is well aligned with the theoretical and methodological framing of this study, and has been used successfully in generating rich data in Indigenous early childhood contexts (Ball & Le Mar, 2011), and health equity research (Browne et al., 2012). The methods of data collection were refined through ongoing dialogue with the CRP and my doctoral committee. As discussed, I also responded to a suggestion from one research participant to provide the option of interviews in small groups.

4.5.1 In-depth Individual and Small Group Interviews

Interview guides⁷¹ that began with surface-level questions, and progressed to deeper questions, were developed for each of the four participant groups with input from the CRP and my doctoral supervisors. The questions were aligned with the overarching purpose and objectives of this research. Individual and small group semi-structured interviews followed the same interview guides. However, the flexibility of semi-structured interviews allowed me to ask structured questions relevant to the central focus of the study across interviews with each participant group, and to be responsive to areas that were spontaneously initiated by each participant (Berg & Lune, 2012). A pilot

⁷¹ Copies of the interview guides are in Appendix H.

interview undertaken with an AIDP worker who met the recruitment criteria provided helpful insights into how to frame and pace the consent process and my line of questioning. This pilot interview generated important insights relevant to the research questions, and was subsequently transcribed and entered as data.

Individual interviews were undertaken with nine AIDP workers and with five caregiver participants, one Elder, and three administrative leaders from different regions in BC. As far as possible, participants were given choices of when and where interviews took place. Although in-person interviews were preferred, seven interviews were conducted by phone⁷².

Interviews were also undertaken in four separate small groups made up of: (1) five caregivers and an Elder in the Northern region; (2) two Elders in the Vancouver Coastal region; (3) five AIDP workers in the Northern region, and (4) four AIDP workers in the Vancouver Island region. An advantage of using ‘pre-existing groups’ for interviewing is that the participants had a level of comfort and familiarity with each other that facilitated discussions (Berg & Lune, 2012). Interaction amongst the group also prompted participants to react and build on other participants’ responses that may not have been forthcoming in an individual interview (Berg & Lune, 2012). Being in a small group, in which there was a level of familiarity, may also have increased participants’ feelings of comfort and safety in expressing their views and served to attenuate my power. Interviews ranged in length from one to two hours.

⁷² Phone interviews were undertaken with one caregiver, four workers, and two administrative leaders as a result of participants’ choice or their location in a part of BC I was unable to visit.

The order and focus of questioning varied and shifted over the course of data collection as I developed a greater awareness of how participants responded to particular lines of questioning, and in response to emerging analytical insights that I sought to explore. With signed consent, all interviews were audio recorded. With all participants, but particularly with caregivers and Elders, my primary concern was their emotional and cultural safety during the interview process. I sought to use a conversational style of interviewing, in which I adapted the line of questioning in response to each participant's particular story, focus, and non-verbal cues. Evidence suggests that research interviews that are conducted with respect and sensitivity can be affirming experiences for Indigenous peoples who experience social marginalization (Browne, Varcoe, & Wong, 2007b). I was unaware of any instances in which participants felt uncomfortable about the interviews, and many participants voluntarily reported afterward that they had found the experience rewarding and enjoyable. Many interviews lasted longer than I had anticipated and conversations that were more social in nature frequently continued after the audio recorder was turned off. This is not to say, that my social identity and positioning did not influence the interviews and I explore this in more detail later in this chapter.

4.5.2 Field Notes

Before each in-person interview, I asked permission to take notes but limited my field notes to a short form to be able to focus my attention on the participant(s). This approach was particularly salient for caregivers and Elders, who may have felt uncomfortable by extensive note taking. More detailed descriptive field notes were written and/or audio recorded immediately after each interview. Throughout data

collection I also kept methodological field notes on the research process; theoretical field notes to highlight any linkages or insights with particular theoretical perspectives or literature, and self-reflexive field notes on my positionality including relational dynamics, feelings, and assumptions (Emerson, Fretz, & Shaw, 2011). In addition, I recorded descriptive field notes on my informal observations on: (a) the physical space and milieu of host organizations; (b) how the physical space created opportunities for families to interact with a range of family and children's services and programs, and (c) how Indigenous peoples were represented in the physical environment and available resources. My field notes were later transcribed and used as data.

4.5.3 Participant Observation

At the start of the research, there were two intended areas of foci for participant observation: (1) informal observations of the common areas of three different host organizations, and (2) more focused observations of AIDP workers during their home visits with families. Participant observation provides contextual information and insights that cannot be gathered through narratives, including the relationship between people's words and their actions (Mulhall, 2003). I had not had any contact with these AIDPs or host organizations prior to this research, and the visits to three host organizations allowed me to gain further insights into how each AIDP was situated in relation to its unique organizational and geographical context. Informal observations were conducted in the communal areas, including reception areas, hallways, and spaces in which caregivers and/or their children participated in AIDP group programs, of the three host organizations that I visited during data collection. Following one such visit, I was given permission to attend a group program facilitated by two AIDP workers and two Elders.

On entering data collection, my intent was to undertake more specific participant observation of several AIDP workers for 3-4 hours of their day as they undertook routine activities including home visits to families who had given their informed consent. These data would have provided more contextual information on how workers related with family members and helped me to understand the nuances between what workers say and what they do. However, workers who participated in interviews or joint interviews were not forthcoming when I subsequently sought, on numerous occasions in person, by phone and/or email, to my requests to shadow them during their routine work with individual families. As will be discussed in the findings chapters, workers spent extensive amounts of time engaging families in their programs and building and maintaining safe and trusting relationships over the course of several years. In seeking to generate an understanding of how EI was potentially influenced by different geographical and organizational contexts in BC, and given the scope of funding and the parameters of a doctoral study, I was unable to travel and spend extensive amounts of time building relationships with families who were accessing the AIDPs that participated in this study. This may explain the difficulty I encountered in seeking to undertake more focused participant observation. The small group interviews did, however, provide opportunities to observe the relational and emotional dynamics within the group including how participants talked to, and about, each other and their shared or differing experiences or perspectives (Berg & Lune, 2012).

In summary, despite the challenge accessing more focused participant observation, the data generated through multiple interviews, field notes, and informal observations provided meaningful and rich information on the complexities and

particularities of how AIDPs influenced family and child health and well-being and fostered child health equity.

4.6 Data Analysis

The theoretical perspectives that informed this inquiry provided a critical analytical lens that generated knowledge on the complexities and specificities of families' lives and the multifaceted ways in which AIDP workers influenced their health and well-being and fostered children's health and health equity. Intersectional analyses reduced the risk of simplistic or essentializing narratives, as participants' experiences were understood in relation to their social identities, historical positioning, and broader contextual factors.

An iterative and nonlinear approach to thematic analysis of the data was undertaken using procedures described for narrative and observational data (Braun & Clarke, 2006). Data collection and analysis occurred concurrently (Braun & Clarke, 2006). The analytical procedures were recorded in an audit trail and are summarized below. However over the course of the 18 months, from starting data collection to formulating my findings for this dissertation, my analysis moved in 'analytical circles' (Creswell, 2013) rather than a neat and linear process as the following description may suggest.

(1) Data Management: After audio-recordings of interviews and joint interviews were collected, they were transcribed and anonymized by a professional transcriptionist, who had signed a confidentiality agreement. I reviewed each transcript whilst listening to the audio recording for accuracy and to attend to the emotional tone and intensity of participants' responses. I transcribed field notes and observational data. I uploaded all

transcripts (source material) into a database in HyperRESEARCH[®], a qualitative software program for organizing and grouping data. **(2) Data Familiarization:** My preliminary reading and re-reading of transcripts as they were collected generated analytical memos that recorded my initial impressions, recurring patterns of interactions, and questions raised by the data. Once data collection was finished I read the entire corpus of data, which generated further analytical insights and memos.

(3) Development of a Code Book: My repeated and reflective reading of the data at a textual level informed the systematic generation of initial topic-based codes and my development of four codebooks for each participant group with differential definitions. My doctoral supervisors reviewed several transcripts, and coding categories and descriptors were discussed and refined. As there was substantial overlap between the four codebooks, each codebook was crosschecked for similar codes and one initial and inclusive codebook was used for the preliminary coding phase. Descriptors for each code were kept broad and inclusive. **(4) Preliminary Coding:** Preliminary coding of all transcripts was conducted using HyperRESEARCH[®]. This software allowed me to use one codebook whilst being able to access and analyze data from each of the four participant groups separately. Data were not kept in one category but could be coded in multiple categories.

(5) Development of Initial Analytical Themes: Consistent with the theoretical and methodological framing of this study, analysis started with the interviews from Indigenous caregivers and Elders. Preliminary analytical themes were developed to help understand the lived complexities of families' lives, their children's health and well-being, and the effects of structural inequities. Caregivers' socio-demographic information

was contextualized through their narratives to provide important insights into their everyday lived experiences and was extended by the perspectives of the other participants. Preliminary analysis also focused on how AIDP practices were perceived and experienced by caregivers. Writing and visual mapping at this stage provided an important contextual foundation of caregivers' lived experiences prior to analyzing any data from AIDP workers (see Appendix I). **(6) Secondary Coding:** Using HyperRESEARCH® all of the source material that had been initially coded as broad and large data sets under 'AIDP practices', 'AIDP policies', and 'navigating systems' were reviewed and recoded. This process generated multiple sub-codes. For example, recoding the largest data set initially coded under 'AIDP practices' generated 18 sub-codes and descriptors. As a dynamic and evolving analytical process, coding categories were revised, refined, and collapsed or expanded. This became my working data set that I returned to repeatedly as it allowed me to easily identify how a theme or subtheme was visible in the data. **(7) Visual Mapping:** Re-thinking and deepening the analytical process was aided by physically working with the data. Visual diagrams and mind maps were an important feature throughout every step of the analytical process. These were developed and continually revised to support my analysis of the complexity, conceptual relationships, and intersections between themes.

(8) Refining and Conceptualizing Analytical Themes: Ongoing data immersion and analysis resulted in my returning repeatedly to the research questions, some key literature, my field notes, and my analytical and theoretical notes to support my thinking with the data. My analysis and critical thinking was supported through regular discussions with my doctoral supervisors. In this process, sub-codes evolved into themes.

Several key themes and broader conceptualizations were subsequently identified. Some themes developed easily and were not surprising, while other themes were unexpected.

(9) Initial Synthesis of Findings: Themes were refined, clarified, and synthesized into findings that addressed the research questions. A recurring self-question during the analytical process was whether my representation of the findings would resonate with AIDP workers and whether they would be able to see themselves and their programs in the findings. Consistent with the methodology and theoretical perspectives informing this study, a preliminary synthesis of the findings was shared and explored at two community meetings. These meetings involved the CRP, several AIDP workers and an Elder who had participated in the study, several AIDP workers and regional advisors from across BC who had not participated in the study, and a wide range of stakeholders that represented both Indigenous and mainstream early childhood and EIT programs in Northern and Vancouver Coastal regions of BC. Dialogue at these meetings helped to clarify and extend my preliminary analytical insights and themes, and shaped and enhanced my framing and representation of the findings.

4.7 The Quality and Rigor of the Research Process and Outcomes

The quality and credibility⁷³ of the research process and outcomes was underpinned by multiple inter-related strategies that were informed by the literature on decolonizing (Chilisa, 2012; Denzin, Lincoln, & Tuhiwai Smith, 2008; Wilson, 2008) and qualitative methodologies (Berg & Lune, 2012; Tracy, 2010). These strategies, or approaches, were refined through ongoing dialogue with the CRP and my doctoral

⁷³ Credibility refers to the trustworthiness, authenticity, and reasonableness of the research findings (Tracy, 2010).

supervisors, and as will be discussed, a continual process of self-reflexivity. To make the key steps and decisions in the research process transparent, I kept an audit trail (Carcary, 2009). Also as previously discussed, I wrote field notes to make my methodological, theoretical, and analytical decisions explicit and promote self-reflexive analysis of key concerns, assumptions, and questions.

4.7.1 Credibility of the Findings

The credibility of the findings was enhanced by employing ‘multiple lines of sight and action’ in the research process (Berg & Lune, 2012). Credibility of the findings was strengthened by the diversity amongst participant groups and research settings, and by the triangulation of narrative data gathered through individual and group interviews, socio-demographic data, field notes, and informal observational data (Berg & Lune, 2012). The credibility of this study was further strengthened through: (1) the coherence between the research purpose and questions with the theoretical and methodological framing of this study (Tracy, 2010), and the foregrounding of participants’ tacit knowledge and the complexities and specificities of their perspectives and experiences; (2) my relationship with the CRP and their engagement in preliminary analysis and findings; (3) two community meetings, as previously mentioned, to discuss preliminary analytical themes and an early synthesis of the findings with key stakeholders; (4) regular debriefings with my doctoral supervisors to refine the coding process, discuss analytical themes and insights, and synthesis of findings, and (5) ongoing critical self-reflexivity.

4.7.2 Self-Reflexivity

Reflexivity has become a common and accepted methodological tool used in qualitative research to question and validate research practices and representations

(Alcoff, 2009; McCorkel & Myers, 2003). Reflexivity⁷⁴ is a key feature of the theoretical perspectives and methodologies that inform this research, and builds on the discussion of my positionality from the previous chapter. As the primary data collection instrument in this study, self-reflexivity on my cultural, social, political, theoretical, and personal self in relation to the research process was foundational to the quality and credibility of the findings (Chilisa, 2012; Donner & Chari, 2010; Kovach, 2009).

The practice of ongoing self-reflexivity that I brought to this research built on, and was a continuation of, a process that started many years before in my occupational therapy practice with Indigenous community members and families (Gerlach, 2007). Reflexive field notes, that started during my doctoral coursework as I explored my research interests and motives, were kept throughout the study as I reflected on my positionality. During data collection, I became aware of the fluid and relational nature of my positionality in relation to different research participant groups (Alcoff, 2009; Hoskins & White, 2013). In particular, I reflected on how my intersectional social identities of ‘Euro-Canadian, female, researcher, occupational therapist, and mother’ shaped how I sought to build rapport, find common ground, and create ‘an ethical relational space of engagement’ (Ermine, 2007) with each participant:

Methodological field note: I tend to share my role as a mother as well as my background of working in First Nations communities as a way of finding some common ground. I think I use these aspects of my identity with caregivers to put them at ease although I don’t consciously think of this at the time. Whereas with

⁷⁴ Pillow (2003) describes reflexivity “as involving ongoing self-awareness during the research process which aids in making visible the practice and construction of knowledge within research in order to produce more accurate analyses of our research. . . . It is a deconstructive exercise for locating the intersection of author, other, text, and world” (Pillow, 2003, p. 178).

AIDP participants I tend to share my professional identity as a way of conveying that I understand what they are saying.

My choice of theoretical perspectives and methodological framing reflected and strengthened my moral commitment to critically and reflexively attend to and attenuate the socially and historically constituted position of power that I occupied in this research (Khan et al., 2007). As noted by Tuhiwai Smith, “the spaces between research methodologies, ethical principles, institutional regulations, and human subjects as individuals and as socially organized actors and communities is tricky ground” (2005, p. 85). In navigating this ‘tricky ground’ I drew on my experiential and theoretical knowledge of cultural safety (Gerlach, 2007, 2012) to critically and reflexively attend to how power influenced and played out in the research process, particularly in my relational practices with research participants (Reimer Kirkham & Anderson, 2002). Thus I consciously sought to move away from ‘researcher as expert knower’ towards ‘researcher as learner’ in a collaborative process of knowledge generation (Hartrick Doane & Varcoe, 2015). The following is an excerpt from my methodological field notes:

Methodological field note: There is a dynamic balancing process in the interviews whereby I continually attend to my agenda and the verbal and sometimes emotional responses of the participants. I think this is particularly the case where the power imbalance is more evident: with caregivers and with one or two AIDP participants who I sense feel somewhat intimidated by the interview questions. Perhaps because of my clinical background, I attempt to be responsive to the participants’ needs first and my agenda is secondary.

I consciously used a number of strategies to attenuate my power including: (1) the nature of my relationship with the CRP that was characterized by ‘a bidirectional flow of knowledge’ (Ross et al., 2010) as we collaborated on the research purpose, methods,

intended outcomes, preliminary analysis, and knowledge translation; (2) the use of plain language to clearly convey both verbally and in writing information about the study; (3) reviewing the voluntary nature of the study with all participants at each data collection time point; (4) providing the choice of individual or small group interviews; (5) being as flexible as possible in timing and location of data collection; (6) conducting interviews in a conversational style; (7) developing KTE activities and products with the CRP, and (8) sharing research findings in ways that were meaningful and accessible to research participants. I was also mindful, however, given my social identities, that it is impossible to fully erase the power differentials between research participants and myself (O'Riley, 2004).

4.7.3 Representation

Kovach (2009) reminds us that “we know what we know from where we stand. We need to be honest about that” (p. 7). My positionality and social location in this research, is inseparable from the knowledge I produced from this study (Alcoff, 2009). Knowledge construction required that my longstanding advocacy with Indigenous families and ECD colleagues was counter-balanced with a rigorous and systematic approach to analysis and writing (Reimer Kirkham & Anderson, 2010).

Consistent with the epistemological and theoretical perspectives that informed this study, my methodology foregrounded the relational and contextual nature of knowledge generation (Wilson, 2008). Representing the findings, thus involved an ongoing self-reflexive process in which I re-read sections of transcripts, and analyzed the relationship between coded data and how I was conceptualizing and representing the findings in writing. During the writing process, I employed several strategies that helped

to interrogate and challenge how I was making sense of the data, including: (1) discussing an early synthesis of the findings, as previously mentioned, with the CRP and at two community meetings; (2) reviewing my coding and analysis of numerous transcripts with my doctoral supervisors, and (3) returning to key literature during analysis and writing to test out my findings with existing evidence. The key findings and recommendations were also reviewed and refined through discussions with the CRP.

In interpreting and discussing the findings in relation to female caregivers, my intent is to foreground their agency, strengths, and resistance while at the same time in no way diminishing the very real challenges they faced in raising a family. This intent is aligned with my theoretical and methodological perspectives and reflects my ‘relational accountability’ (Wilson, 2009), particularly as a non-Indigenous researcher, to avoid inadvertently contributing towards a discourse in which Indigenous women are ‘inferiorized’ in their mothering roles (Tait, 2000). During the writing process, I also had several discussions with the CRP about representing findings that were potentially unflattering for AIDPs. In the context of the findings as a whole, we agreed that these findings had important implications and should not be excluded.

4.8 Ethical Considerations

Wilson (2008) highlights the need for relational accountability and integrity in making moral and ethical decisions on which knowledge is sought, how it is gained, analyzed, and used by the researcher. Ethical considerations, as they built on my relationships and relational accountability to participants and the CRP, informed every aspect of the research process (Chilisa, 2012; Wilson, 2008). I consciously sought to undertake research that was decolonizing and praxis-oriented, and used procedures that

were consistent with recommendations and guidelines for conducting research that involves Indigenous peoples (Canadian Institutes of Health Research et al., 2014). My university's Behavioural Research Ethics Board also approved the research procedures.

Ensuring participants' confidentiality was an essential element of the trusting relationship between participants and myself (Canadian Institutes of Health Research et al., 2014). Methods for ensuring confidentiality were outlined in the information brochure and consent form and discussed with prospective participants during the consent process. In small group interviews, the consent process was augmented by my verbal request that participants respect each other's confidentiality by not sharing our discussion outside of the group. To protect confidentiality, physical, administrative, and technical safeguards were employed to ensure that data were securely protected. All direct and indirect identifying information was irrevocably stripped from the data, and each participant or group were assigned an alphanumeric code. The list that linked participants' assigned codes with identifying information was password protected, kept separately from the data set, and was accessible to my doctoral committee and myself. The CRP did not have access to this information.

4.9 Knowledge Translation and Exchange

From a critical perspective, KTE is responsive to local processes of knowledge sharing and utilization (McGuire, 2010; Smylie et al., 2009), resists a one-way, linear process of knowledge dissemination, and is shared in a manner that engages with and informs policy stakeholders (J. M. Anderson, 2002). The process of KTE is informed

through an ongoing dialogue with the CRP to identify key knowledge-users⁷⁵ and to ensure that the results are shared and discussed in ways that are respectful, meaningful, and beneficial to Indigenous families and communities; AIDP workers; host organizations, and a broad professional audience (Canadian Institute of Health Research, 2010; McGuire, 2010).

As a central ethical concern of a decolonizing methodology, ‘reporting back’ to research participants and ‘sharing knowledge’ continues into the present to ensure that “research reaches the people who have helped make it” (Tuhiwai Smith, 2012, p. 16). With this goal in mind, KTE activities that have been undertaken or are currently underway include: (1) information sharing and discussion forums with community organizations that serve Indigenous families and children who participated and/or expressed an interest in the study, and (2) distribution of a summary report of the study to all research participants who requested a copy; AIDP steering committee members; all AIDP workers, and administrative leaders of host organizations in BC. A link to the report will also be available on the AIDP website and offered to host organizations to put on their websites and/or in their newsletters.

Sharing the findings to engage with policy stakeholders will include co-authoring with CRP a briefing note for the Maternal-Child Health Committee of the FNHA, and the Early Years Office of MCFD, and meetings with key policy stakeholders in the FNHA and MCFD. Sharing the findings more broadly will include national and international: (1)

⁷⁵ Knowledge users will be inclusive of Indigenous caregivers; Elders; AIDP workers; administrative leaders of AIDP host organizations; the Indigenous ECD community; Indigenous ECD policy-makers, and the broader ECD and EIT community.

conference presentations with a broad, interdisciplinary audience⁷⁶, and (2) multiple papers in peer-reviewed health, social science, rehabilitation and early intervention journals. Sharing knowledge generated by this study is a long-term commitment (Tuhiwai Smith, 2012). Upon completion of this study, my relationship with the CRP will continue as we collaborate on KTE strategies that make as full use as possible of the findings to inform AIDP practice, education, and policy.

4.10 Limitations of this Research

The majority of caregivers who access AIDPs are women. Aside from the one father and male Elder, male perspectives were largely absent from this study. This is consistent with evidence on the absence of Indigenous fathers in, and feelings of social exclusion from, programs for infants and young children (Ball, 2009; Mussell, 2005; National Collaborating Centre for Aboriginal Health, 2011). The absence of teenage mothers is salient given that workers and an administrative leader noted that an increasing number of teenage mothers were ‘losing their infants’, often at birth, to the child welfare system.

While many of the AIDP workers in this study provided outreach to on reserve communities, the focus of this study was primarily on families and programs in urban settings. The findings may not be generalized to AIDPs in on-reserve communities who receive more stable federal funding and have typically developed in closer collaboration with local health care centers (D. Elliott, personal communication, May 10, 2012).

⁷⁶ A co-presentation with the CRP at the International Indigenous Child Health Meeting in Ottawa took place in March 2015. The findings are being presented at the Asian Pacific Occupational Therapy Conference in New Zealand in 2015. An abstract has also been accepted for the international ‘Early Years’ conference in Vancouver in 2016.

Similarly, they may not be applicable to AIDPs that are located in more rural or remote communities in BC.

This study reinforces the importance of spending time in community and building relationships with families over an extended period of time. My inability to do this, as a result of the financial and time constraints of doctoral work, and the regional focus of this study, contributed towards my not being able to do more focused participant observation between workers and caregivers during home visits.

4.11 Concluding Comments

The philosophical underpinnings of decolonizing methodologies provided an ethical and relational framework for implementing this research. This study would not have been undertaken without the full support and participation of the CRP. The quality of this research is enriched by a complexity of theoretical perspectives, multiple contexts and participant groups, and analytical procedures that generated nuanced and complex findings relevant to the research questions.

CHAPTER 5: A RELATIONAL ORIENTATION TO EARLY INTERVENTION

5.1 Orientation to Findings Chapters

The following two findings chapters focus on the multifaceted ways in which AIDP workers influenced families and children's health and well-being and addressed social and health inequities affecting families⁷⁷ and children living in conditions of social disadvantage. I view these findings as significant because they represent innovative approaches to conceptualizing and providing EI.

Consistent with interpretive approaches to inquiry, I am integrating literature as a way to interpret the findings. The findings are organized into two inter-related chapters. In **Chapter Five**, analysis focuses on how workers' knowledge of families' lives developed through a relational process of inquiry. This is followed by an analysis of the findings on families' lived experiences of structural inequities and violence. The findings in this chapter provide an essential contextualized foregrounding for the findings in the following chapter. In **Chapter Six**, I draw on and extend Wilson's concept of 'relational accountability' (2008), to discuss workers' relational orientation to EI. In this chapter, I discuss how AIDP workers provided EI in ways that were tailored for families living in urban community⁷⁸ contexts and were highly responsive to the realities of families' lives,

⁷⁷ Participants used the gender-neutral terms of 'families' and 'parents' interchangeably, with occasional references to 'moms' and occasionally to other family members. While mindful of the diverse nature of family structures, the workers in this study noted that women headed many of the families served by urban-based AIDPs.

⁷⁸ Drawing on the work of Hartrick Doane and Varcoe (2015), I conceptualize 'community' here relationally, as 'living relational experiences' that are situated and constituted within wider contexts.

including their experiences within the health care and child welfare systems. This chapter also addresses the tensions and challenges faced by AIDP workers as they crossed the contested terrain of ECD and child welfare in BC. It concludes with findings that raise concerns about the increasingly complex relationship between AIDP workers and the child welfare system.

5.2 Relational Understandings of Family Health And Well-Being

This initial findings chapter focuses on AIDP workers' relational understandings of family health and well-being. First, analysis focuses on how workers' engaged in a relational and contextually embedded process of knowing that led to a broader and strengths-based perspective of family well-being. Second, the analysis focuses on the findings that highlight how intersecting structural inequities and violence shaped families' everyday lives. Third, analysis focuses on an examination of discourses on intergenerational trauma. The chapter closes with a summary of the key points raised.

5.2.1 Learning *from* Communities and Families

In mainstream EI programs, such as the IDP, workers typically learn *about* a child's health, development, and family context by asking caregivers direct questions that often involve a standard initial interview process and standardized developmental screening tool. In contrast, AIDP workers reported how they learnt *from* communities and families through a deeply relational and personal process of inquiry. In the following excerpt, a worker describes how learning from a mother about her experiences of growing up in the foster care system had shaped and informed how she related and responded:

W⁷⁹: When I talk to her now I look at things really differently because in her conversations like when she's frustrated or when she's sort of looking for support it doesn't really come out in a way that I think other professionals necessarily interpret well. So I'm sitting there and I'm thinking oh no, I think this is what she's kind of saying and so I'll ask her. So I help her sort of interpret to get her needs met. (P29)

Whereas, learning *about* a child and family suggests a degree of social distance, learning *from* foregrounds proximity and relationships (Britzman, 1998). The depth and often-personal nature of workers' learning *from* caregivers about their story, history, and daily lives was embedded in their experiences of being and relating with families in the intimacy of their homes, local neighbourhoods, and diverse community settings. Findings highlight how workers' knowledge and perspectives of families' lives were embedded in their experiences of walking with a mother and her infant daughter to the local playground, having a cup of tea with a mother in her kitchen, chatting with a father at a drop-in playgroup, or driving a mother and her infant son to the grocery store.

Rather than a depersonalized relationship with, what Thayer-Bacon (2003) has referred to as 'surface knowledge', workers recognized the value of expanding their understandings of family well-being by 'being really open' to talking to and learning from caregivers, as discussed in the following excerpt:

W: I think that we come in and sometimes we have education and . . . we come with our degrees or our ECE and our schooling and those things are very helpful but . . . the home-visiting program those kinds of things right, those are when we get our 'ah-ah' moments. And really being open to talking to people and learning from others and recognizing that we consistently have that learning curve. And we'll do something; we'll walk into someone's home and we might make a

⁷⁹ In order to identify the different participant groups the following abbreviations are used in combination with the numeric code assigned to each participant: M = mother; F = father; W = AIDP worker; E = Elder; AL = Administrative Leader; P = Participant; 'FG' is used to indicate a focus group, and R = myself as the primary researcher.

mistake, and being aware of the body language, or what's being said to us, and learning from that experience and then changing it the next time. (P06)

Workers' explained how their learning from and with families was a participatory and reciprocal process:

W: What was successful was I just created the space to always listen when [a mother] needed to say what she needed to say. . . . So there was lots of reciprocity in the relationship. . . . That's the key thing I recognize as success, is the reciprocity because it wasn't me just doing, do you know what I mean? There was like a cooperative kind of learning space; I was equally learning from her about her culture and her family and the challenges that she was facing and she was learning from me as well. (P07)

Workers were in agreement that the depth and often intimate nature of their knowledge about families' stories and histories was anchored in relationships that frequently developed over the course of several years:

W: It takes time to build up that trust. One mom I worked with her probably a year before she openly said that . . . she's an addict and she uses crack. Before that it just was kind of under the surface . . . she wouldn't openly say that. But now like everything is out there and it's been a couple of years now. (FG1)

Workers also discussed how their own socio-cultural and historical locations influenced their perspectives. As one worker stated: "I think that there is a creative flexible ability in being able to bring myself and my knowledge and wisdom to the whole" (P05). In this way workers tapped into their own life experiences as they sought to relate to the often socially complex lives of many of the families in their programs. As another worker noted: "So it might be very difficult for a new AIDP consultant who's only thirty who maybe was raised in an urban community versus a worker who was born and raised on reserve by a residential school survivor" (P01). Workers also recognized that they brought their own values, assumptions, and "place of privilege" (P06) to their understandings of family well-being. Workers questioned the value-laden nature of their

pre-existing perspectives and assumptions, particularly in the context of visiting families in their homes:

R: What kind of judgments do you need to put aside?

W: You have to be accepting of where they're at. . . . I've had numerous times when I've gone into their home and found it to be total chaos . . . but there is a point when you know that this family is really in chaos. It's spilling out now in their home, so it's being able to put that aside. . . . This is telling me that this family really needs some support like they are overwhelmed is what I think. . . . This job has taught me so much about where are my judgments and why do I have them. (P27)

Reflexivity⁸⁰, as central to a relational process of inquiry (Hartrick Doane & Varcoe, 2015), was evident in how workers consciously paid attention to and questioned their personal and professional assumptions, role, and social positioning as a way of 'keeping their judgments in check'.

5.2.2 'We're Not Only Here for Your Child but Your Whole Family'

Workers' contextualized perspectives of health and well-being were underpinned by an explicit shift away from a focus on an individual child's health and development to one that recognized 'family' as being at the centre of their programs. As one worker said: "For [a] healthy baby you need a healthy family. . . . We just recognized early on that it just wasn't going to work to just focus on the babies" (P06). This perspective is shared in the following excerpt from an administrative leader:

AL: We're doing everything that we possibly can to help families to feel good about what's happening for their children [and] to feel positive about what they're doing as parents for their children. . . . It's tough being a parent, and it's really

⁸⁰ Reflexivity in working with families "involves paying attention to who, how, and what you are being/doing in the moment as you work with families, observing your own living experience of that being/doing and critically scrutinizing your experience, knowledge and actions" (Hartrick Doane & Varcoe, 2005, p. 163).

tough being an Aboriginal parent many, many times. . . . So we want to do everything that we possibly can to surround that family and make them feel as supported and as strong as possible, and we believe as well that if we can develop that personal voice of parents then they're better able to support their children. (P37)

Workers described a perspective of child health that included how families' lives were influenced by broader social determinants and contextual factors:

W: When I think about AIDP . . . it's not just looking at the child, it's looking at the whole structure of the family all the time and what does the family need to keep this child on course right? So it may be that working with a family and for two months you're just helping the mom figure out how to pay her rent and get food. . . . The referral might be about the child, but you might not really be working with the child because right now the mom needs that more than the child in a way. So when I think of AIDP, I just think of the holistic view that has to be taken about where is this family, and how do we support this family and the child is in the middle? So what do we need to do to stabilize the family so that this child can have the best chance? (P27)

Workers' broader perspectives of family well-being were supported through AIDP policies that allowed for a wider age range of children from birth to six years of age⁸¹ to access their programs. Having a wider age range allowed workers to stay involved with a family for longer and/or to be inclusive of siblings of different ages in the same family:

W: You may have three children within that age group and what's happening is, you know, you may be focusing on the infant and then you recognize that the three-year old actually needs more services than that infant right? And so it's like how can you support this mom and this baby when she's busy chasing this three-year old or the three-year old is developmentally not where he or she needs to be so it's making sure that we get those connections for those older children (P06).

As summed up by one worker: "the age of the child is less important than doing what is right for a family" (P27). Also, unlike their mainstream counterpart programs, AIDPs do

⁸¹ The age range for most IDPs in BC is typically 0-3 years.

not require a child to have a developmental delay or diagnosis to be eligible for their programs. Whereas prevailing EI programs aim to identify where a child is at in terms of developmental norms as the entry point for intervention, the AIDP workers described identifying ‘where a family is at’ in terms of their overall well-being. This orientation to family well-being prompted one host organization to re-name their program ‘the Aboriginal Infant *and Family* Development Program’.

Findings demonstrate that a frequent starting point for supporting family well-being was attending to a mother’s health and well-being. Workers discussed the importance of supporting mothers in ‘their growth and health’, as stated by a female Elder who had played an integral role in an AIDP for many years:

E: For the moms, it’s about their growth and their health. . . . If you can’t be number one and take care of yourself there is no way you’re going to be the best support for your children. So you have to look at growing and developing within you and then carrying that over to your children. So the moms that I’ve met [at the AIDP] some of them have just so blossomed. . . . The moms have learned to cook, to garden, . . . they’ve learned a proper diet and other ways of dealing with children when they have tantrums and other ways of finding assistance in the community to give them that respite one day out a month. (P21)

A worker adds her perspective on the importance of maternal health:

W: So if a mother is battling depression or other things, what’s more important during the day, that’s how I look at it too. Does the child really need to learn this puzzle right now or do I need to look at the fact that mom needs to actually be awake, you know, and feed her child because she’s barely feeding herself like, you know, it depends what’s happening right? So it’s kind of looking at and setting goals differently. (P29)

While focusing on maternal health and well-being as a starting point for EI is seemingly commonsense, it is not typical of mainstream EI programs, such as IDP. The positive health outcomes described by mothers, Elders, and workers also highlight the broad perspective of health and well-being that AIDPs represent. Positive health outcomes

included: staying ‘clean’ during pregnancy, knowing how to budget and prepare a healthy family meal, accessing a daycare program, and returning to school or gaining employment.

5.3 Families’ Everyday Lived Experiences of Structural Inequities and Violence

Consistent with the theoretical framing of this study, I sought to generate nuanced and contextualized understandings of how families’ lives were differentially shaped by structural inequities and violence. These findings are presented separately for the sake of clarity in the following section of this chapter. However, the ways in which structural inequities and violence were manifested in families’ everyday lives were often multifaceted and intersectional. The effects of structural inequities on families’ lives were also experienced differentially in relation to each caregiver’s unique circumstances and agency.

5.3.1 ‘I Look Back Now’: The Legacies of State Intervention

A recurring theme that exemplified workers’ relational orientation to family well-being was their knowledge on the intergenerational legacies of state intervention and the role their programs played, as noted by one worker, in the “healing process” (P01). The importance of healing was highlighted by the mothers in this study, who shared their childhood histories of trauma and adversity:

M: I look back now and it’s like because we didn’t eat breakfast, we didn’t have the nourishing loving home. . . .It’s been trauma and violence, and I don’t mean to go off topic or anything but it’s a part of development and if you live with trauma it’s hard to concentrate on anything. It’s living in your body and it’s like you’re so little you can’t sort of tell somebody. Like this is why I can’t sit still; this is why I can’t concentrate on top of not eating breakfast; not coming from a loving home; exposed to violence and exposed to drugs and alcohol. It sort of makes sense when I look back, and so I think just as a starting point AIDP is sort of crucial to the basics. (P26)

Workers' understandings, as they took into account the socio-historical contexts of families' lives, served to disrupt and expand their perspectives on normative and prevailing ECD constructs, such as play. Workers recognized how the legacies of the residential school system continued to filter down to a parent's capacity to play and be playful with their infants and young children. In the following excerpt, a mother, whose parents attended residential schools, reflects on her childhood experiences of play and learning how to play with her infant son:

M: [my parents] never played with us or read books to us. It was very cut and dried like harsh. . . . So for somebody to teach us how to play with our children that is a big deal because we don't know how to do that. . . . So for [the AIDP worker] just to come and sit down on the ground with me and my son and start pulling things out and playing with him. . . . So just watching her interact with the kids was really great and . . . how [the AIDP worker] showed me how to play with him without telling me. (P03)

Workers discussed how women's "stress, trauma from the past as well as everyday living" (P26), their mental health and/or substance use, and their children's health were inextricably connected:

W: So sometimes I'm working with families . . . [with] children that have been raised in and out of care so there's lots of intergenerational trauma as well. So just families that may be disconnected or there's unresolved grief and loss I think is what it comes down to. So there's lots of addiction issues . . . there's different symptoms but it's the same core stories typically. (P29)

A mother adds to this discussion:

M: It's good to learn stuff that I don't have. . . . I have forgotten about raising kids because I used to use for 16 years after losing my first four children. So being a brand new mother again with three more now, yeah, so learning and developing with them. . . . I just needed to ask some basic questions. (P04)

These findings highlight how workers recognized the differential ways in which women's current health and well-being were interwoven with their unique life histories, current circumstances, and the legacies of colonial structural violence.

5.3.2 'It's Threatening No Matter What': The Relentless Gaze of the State

Parents' childhood experiences of structurally rooted forms of adversity were frequently interwoven, or continuous, with stress and trauma in their adult lives, particularly in relation to their ongoing experiences with the child welfare system. Congruent with existing evidence (Representative for Children and Youth, 2013), AIDP workers and administrative leaders across the province reported that the number of children being removed by the child welfare system was continuing to increase at an alarming rate:

AL: In our community, and I'm sure in many others as well, there's so many young moms who are young people that are in the care of the Ministry or they've aged out, who are having babies that are being removed immediately at the hospital . . . and, you know, those numbers are not dropping by any means. (P37)

Caregivers and workers portrayed the child welfare system as a continuation of the residential school system and the 'Sixties scoop'. As one mother said:

M: I know it's very much threatening no matter if they're there to support, no matter what they're there for, it's felt and seen as a huge threat to your livelihood, to your parenting, to your whole family. . . . And as soon as that bond between the child and the mother is taken that's trauma in itself for the mom and the child. And going back from the long history of residential school essentially it just seems like to some people today it's the same sort of thing. It's the government coming to take your child because somebody has reported you as unfit. . . . It just sort of makes me angry because it's like who has the right to come in and do that? The government . . . it's like the big brother that just sort of gets to control your life. And then if you sort of add that to the whole residential school. (P26)

Surveillance, as a powerful mechanism of colonial dominance (Ashcroft et al., 2007), was described by workers as: "living with the Ministry eyes on you all the time

and [where] nothing you do is private” (FG3). Additionally, workers recognized how parents were frequently judged in ways that disregarded their positive attributes, achievements, love for their children and, the impact of socio-economic structural inequities. As a routine aspect of their lives, many of the women accessing AIDPs had experienced being ‘over-policed’ (Cull, 2006), and anticipated having to prove themselves:

M: And the [child welfare social worker] said ‘well, yeah, we’re investigating you but we’re not going to take your child away but you do have to prove to us that you can support yourself.’ So it’s like you have to start jumping through hoops. (P26)

State surveillance and intervention had a profound impact on family’s lives and maternal well-being. This is highlighted in the following excerpt, in which a mother relays her conversation with a child welfare social worker:

M: I was feeling scared. I said I cannot live without my children and if you’re going to take them from me I know for myself I will not recover. I’ll just go off the deep end and I’ll never come back. No amount of money, love, or support will bring me back I can feel it for myself. (P26)

The effects of over-surveillance were also manifested in child-rearing practices. Workers described how some mothers were reluctant to let their children play in puddles or a sandbox, or on age-appropriate playground equipment, for fears of them getting dirty or injured and risk attracting increased state intervention.

5.3.3 Being Suspicious of ‘Anyone Who Takes an Interest in My Child’

Many of the women accessing AIDPs anticipated and/or had experienced judgment, dismissal, and discrimination in their daily lives, particularly in their encounters with mainstream institutions including health care and child welfare. As a result, many women reported feeling suspicious and/or fearful of accessing any child-

related programs. Many of the mothers in this study had experienced having a child removed from their care when they were teenagers or young adults, and voiced their ongoing mistrust of, and vigilance for, ‘anyone who takes an interest in my child’:

M: [The AIDP worker] was always like hi how are you? And for me, I’d given up a child so this was my second child. So for me it was like why is this weird lady trying to be nice to me and she’s trying to get close to my kid because she’s trying to take my baby away right and stuff like that. So I had this like strange thought that you always just try to push everybody away from you, that’s the way I was before. . . . And then I had all these like fears that something was going to happen to my baby and the baby was going to get taken away and stuff. (P03)

Workers’ recognized that a family’s reluctance to allow a worker into their homes and lives was rooted in the socio-historical positioning of Indigenous families in relation to state surveillance and intervention:

W: I would go to in-services and I would hear people talk about [how] sometimes it’s hard to knock on the door and people won’t answer. And in my home community it would be even harder because it might be my relative who’s not answering the door, and a little child that’s looking out the window saying just leave it at the door. . . . But there again I think we come from a history that perhaps has become fear based around the Ministry; around removal of children, and the whole foster care, Sixties scoop adoption piece right? It’s still fresh in people’s minds. (P30)

One worker described how engaging families in an AIDP was in itself a positive outcome:

W: Someone looking outside in may say well there’s no real change in this scenario but what the change was that mom was open and willing to have resources come into her home whereas when I first met her she was so guarded, she was so protective that no-one was coming in. . . . Her children had been removed and in a horrible way . . . basically the police are ripping the children out of the parents’ arms. And so she was angry, she was non-trusting, and very afraid. (P07)

These findings highlight how historical and ongoing state intervention in families' lives can delay or prevent caregivers from accessing programs like AIDPs, and children from receiving EI at a time in their lives where it could potentially have the greatest impact.

5.3.4 'Living in Survival Mode': The Downstream Effects of Poverty

In my experience, the scope of interdisciplinary EI therapy programs, including occupational therapy, typically fails to address the impact of socio-economic determinants on families' everyday lives and children's health and development. In contrast, AIDP workers discussed, and were highly attuned to, the downstream effects of poverty on families' daily lives, and understood how material deprivation was a serious threat to family well-being:

R: Can you give me some examples of some of the things that families are struggling with?

W: I think poverty and the lack of food security. . . . Housing is high up there . . . those are survival level things . . . and transportation. They can't think about child development they need to get food, and sometimes I've gone with families to get hampers . . . just to get through to the end of the month because . . . they're surviving on Ichiban soup . . . whatever is the cheapest. (FG1)

Workers reported visiting families that were living in homes that were "not a safe place"; infested with mice, cockroaches, and bedbugs, with mould on the walls, and "high rent but no heat" (FG3). Workers also reported that families frequently had to choose between buying groceries or paying a heating bill.

Often overlooked in the literature that focuses on 'child poverty' (Hertzman & Bertrand, 2007; UNICEF, 2012) is the ways in which poverty can constrain caregivers' agency. Workers reported how chronic poverty constrained caregivers' agency in attending to particular concerns related to their children's health or development:

W: I work with families that if they don't have enough food or they don't have a place to live, if they don't have a phone, they don't have a job, all those other issues those basic need issues it's really hard to work on the goals for the child because their basic needs are more important. (P30)

The anxiety and stress experienced by caregivers in struggling to provide basic determinants of health for their children was compounded and complicated by their over-surveillance by the child welfare system.

5.3.5 'It's a Double-Edged Sword': When Poverty is Misconstrued as Neglect

Findings show how women's socio-economic status, as it intersected with their historical positioning and experiences of racialization, amplified the likelihood of state intervention. Workers described how families' headed by single Indigenous women on limited income increased the risk of impoverished living conditions being judged and misconstrued as willful neglect within the child welfare system:

W: When we want to criticize a family for sleeping with their infant, you look at the house they're living in, a three-bedroom house with 17 other people. You kind of don't have a choice. So it makes it look like parents aren't being safe. (P01)

Consistent with leading provincial and national critics of the child welfare system (Hughes, 2013a; Representative for Children and Youth, 2013; Sinha et al., 2013b), workers reported feeling frequently frustrated by a systemic failure to acknowledge, or work towards addressing, the structural root causes of perceived 'neglect':

W: I see that with one family currently who's got one child in care and one child with her living in a house with a multitude of people, which is great because she's got the support. But on the other hand there are issues in that family that are deemed by the Ministry not safe. . . . An expectation on that family is to go out and find their own apartment to live together but their income is probably next to nothing. So it's a double edged sword there for them. (P05)

Another worker adds to this discussion:

W: Often most of the family situations, it was poverty and neglect that was removing these kids, which I just struggle with always because I think rather than spending money and pulling these kids out of their homes and spending money over in this [foster] home, why don't you spend the money in that family and keep the child intact but that's not the way it worked. (P07)

These findings provide evidence of how women's roles as mothers were defined to some degree by a punishing web of state surveillance and control that failed to recognize the influence of structural inequities on their daily lives and material circumstances. From this perspective, caregivers' agency in providing food and/or housing security for their children, or having transportation to a health care appointment or a mandated parenting group on the other side of town, for example, were construed by the child welfare system as a result of individual choice and autonomy.

5.4 Interrogating Professional Discourses on 'Intergenerational Trauma'

In this final section of the chapter, I return to the findings on participants' perspectives on intergenerational trauma as a result of various forms of state intervention. My analysis is informed by Maxwell⁸² (2014), who contends that professional discourses on historical and intergenerational trauma in the Indigenous ECD literature in Canada is complicit in perpetuating "the idea that parenting constitutes a discrete mechanism by which trauma is intergenerationally transmitted" and "provides a new discursive tool for the pathologization of indigenous families" (Maxwell, 2014, p. 420).

Workers, Elders, administrative leaders, and mothers voiced their concerns that a central challenge facing many parents was knowing how to nurture their children in a

⁸² It has been argued by Maxwell that "it is empirically impossible to isolate the psycho-social effects of particular historical experiences, such as residential school attendance, from the broader context of indigenous people's past and present experiences of the complex and shifting range of policies and practices which make up Canadian colonialism" (2014, p. 425).

safe and healthy way when they had lacked these experiences in their own childhood. As one Elder stated, “they [mothers] don’t have an understanding of how to be with children” (E23). A worker expands on this issue:

W: I think that’s part of the historical trauma. . . . We have these young people who are having babies who have grown up as a product of residential schools and they have not grown up in a healthy family context because of that. And so play and that natural sense of wonder, I don’t think it can occur in those unsafe environments and in those damaged systems. And so if you’ve got a child who was raised in an abusive situation, or in a care setting, or in a residential school who modeled play with them? Who taught them to engage . . . with their little ones? (FG3)

It is not my intention to minimize or dispute the experiences of individuals, families, and communities impacted by the trauma of historical and ongoing forms of state intervention. I am concerned, however, that the apparent assumption that parents’ lack of ‘understanding of how to be with children’ is conveyed as being inevitable and applicable to all parents. As one worker stated: “I think that generational trauma is so deeply ingrained and I’m thinking not just with the clientele but myself as a service provider” (P05). I therefore question whether workers’ ‘deeply ingrained’ perspectives on intergenerational trauma tacitly disregard parents’ agency and resistance in the context of diverse personal, family, and community experiences and factors. I am also concerned that this perspective unintentionally contributes towards pathologizing Indigenous parenting and legitimizing the need for ongoing state intervention (Maxwell, 2014).

Many of the mothers in this study reported that they had experienced having children removed from their care in their late teens or young adult lives. Now in their mid-thirties, mothers discussed how their participation in AIDPs had supported them in (re)claiming their agency as mothers. Women discussed how they wanted to “to break the

cycle of what we went through growing up” and “raise our kids differently from the way our parents raised us” (FG2). In alignment with existing research on pregnancy and early parenting as an opportunity to turn around the effects of intergenerational trauma and associated substance use (Rutman, 2013; D. Smith, Varcoe, & Edwards, 2005), workers also recounted many ‘success stories’ of parents in their programs:

W: And hearing that . . . if mother gets pregnant again that they’re having healthy babies, you know, oh this time I didn’t use at all. You know I have no concerns for this child because I know I didn’t use at all, it’s really something to hear.
(P02)

At the time of their interviews, all of the caregivers in this study were exerting their agency in raising their children by being actively involved in an AIDP and by accessing other services and resources for their own and their children’s health and well-being. There were also ‘many success stories’ whereby women had used pregnancy and early parenthood as a time to access health care services to address their own health care needs, to return to school or find part-time employment, and/or had taken on leadership roles in AIDPs or their host organizations. These findings suggest that contrary to how workers’ narratives implied a sense of inevitability in relation to intergenerational trauma, they also believed that given the right timing and support it was possible to disrupt the ‘forward movement’ of trauma from one generation to the next (Campbell & Evans-Campbell, 2011).

5.5 Chapter Summary

The findings in this chapter illustrate how workers’ knowledge and perspectives of families and children’s health and well-being were anchored in a relational process of inquiry (Hartrick Doane & Varcoe, 2015). Workers’ broad perspective of family well-

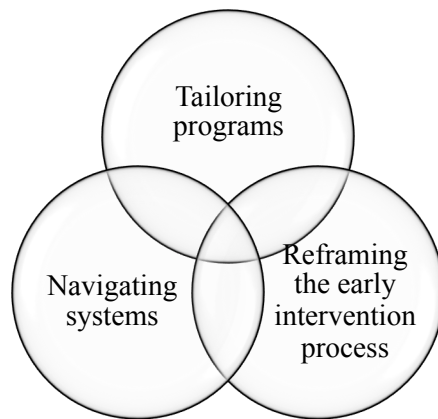
being disrupts the decontextualized and ahistorical child-focused individualism of prevailing ECD and health discourses, and is well aligned with the conceptual underpinnings of cultural safety (Gerlach, 2007, 2012; Ramsden, 1993, 2005). These findings illustrate how intersecting and cumulative structural inequities and violence that were frequently beyond individual caregivers' control, created conditions of social disadvantage for many of the families and children who accessed AIDPs.

A broad and contextualized perspective of Indigenous children's health, that takes into account the multifaceted impact of Indigenous and social determinants, is increasingly recognized in the literature (Greenwood & de Leeuw, 2012; Greenwood et al., 2015; Reading & Wien, 2013). Perhaps more significant in this study, is how workers translated their nuanced and broader understandings of family well-being into their routine practices. This is the focus of Chapter Six.

CHAPTER 6: RELATIONAL ACCOUNTABILITY IN THE EARLY INTERVENTION PROCESS

This chapter focuses on the findings that illustrate *how* AIDP workers influenced families and children’s health and well-being and were responsive towards social and health inequities affecting families and children. In conceptualizing how workers’ enacted relational understandings of family well-being in their routine practices, I draw on Wilson’s concept of ‘relational accountability’⁸³(2008). Taking up and extending the concept of relational accountability to the context of EI draws attention to how workers recognized that their knowledge of families and communities must be used respectfully, responsibly, and in ways that directly benefited individual and collective well-being. In the first section of this chapter, I discuss three distinct ways in which workers enacted their relational accountability to communities and families (Figure 1).

Figure 1: Relational Accountability in Early Intervention



⁸³ As discussed in Chapter Three, in defining relational accountability in the context of an Indigenous research paradigm, Wilson states that “the methodology needs to be based in a community context (be relational) and has to demonstrate respect, reciprocity and responsibility (be accountable) as it is put into action” (2008, p. 99).

In the second section of this chapter, I discuss how workers traversed a contested terrain of EI and child welfare in BC. The chapter closes with a summary of the key points raised.

6.1 Tailoring Programs for Urban Contexts

Workers enacted their relational accountability by designing and delivering AIDPs that were tailored for diverse community and organizational contexts. As one worker noted: “We have this overarching philosophy, vision, and mandate but each program can be unique to their community” (P01). Findings highlight how the broader geographical, socio-economic, and historical contexts in which communities⁸⁴ were situated shaped programs so that, as one worker stated, each program was “built to be within this community” (P38). Similarly, an administrative leader reported that her organization had “taken the model of AIDP” and “made it a fit for our organization and our community” (P37). How AIDPs were contextually tailored is the focus of the following section.

6.1.1 Disrupting a Prescriptive Approach to Early Intervention

Workers described spending extensive amounts of time building relationships with, and learning from, community leaders, Elders, and other key stakeholders about their particular community context:

Field note entry: It was surprising to hear [a worker] say she spent six to eight months building relationships with communities before even offering any programs or services. Building a presence in communities; building relationships and learning through those relationships who were some of the influential families

⁸⁴ Drawing on the work of Hartrick Doane and Varcoe (2015), I conceptualize ‘community’ relationally as ‘living relational experiences’ that are situated and constituted within wider contexts.

or individuals/Elders in the community; and taking direction from each of the First Nations they serve as to what kinds of programs they wanted. So that although the AIDP contract was held by the [name of host organization], how each program looked in the different communities was dependent on what the community identified as being important.

A worker (P07) adds to this discussion:

W: If we're going to do this, the way we need to do it for our communities, then we need to create space and time for a relationship building and partnership process. . . . We felt it was important to make sure that the communities felt that they always had a voice in our programs so we just created space for that. (P07)

As workers noted, “doing introductions with the whole community not just one family at a time” (P23) enabled them to be respectful of, and responsive to, community-specific protocols, self-identified community priorities, and existing resources and relationships with other family and child related programs. In this way, program design and implementation were tailored in ways that had the greatest potential to be responsive and beneficial for each community. The following excerpt highlights what happened when a worker failed to provide a program in this way:

W: Well the things that didn't work . . . when I tried to do parenting programs and workshops it was me who decided oh well they need to learn about nutrition, they need to understand the pros and cons of making decisions about getting your child immunized. . . . So I set up like all of these parenting groups and I set up the topics, I set up the agendas, I set up the snacks and nobody was coming. I'd have two to four mums and I was going oh crap what's wrong here. (P01)

The extent to which AIDPs were tailored for specific communities was, however, a point of tension raised by some workers who expressed their concerns that this needed to be balanced with some definable unifying ‘core understandings’ or essential elements:

W: We're still learning what's right from one community to the next and really what's right in one community may work a little differently than the other but we still need that core understanding. (P06)

The ways in which workers' tailored their programs for particular community contexts signifies a distinct shift in power and expectations in early childhood program-community relationships. Contextually-tailoring programs disrupts the tendency for standardized or normative early childhood programs to be imported into communities in ways that disregard communities' agency, preferences, and the uniqueness and diversity of each community (Ball & Le Mar, 2011; Lynam et al., 2010).

6.1.2 Creating Places of Physical and Emotional Safety

Findings highlight how urban-based AIDPs, in different regional and organizational contexts, were tailored for women who experienced socio-economic marginalization and various forms of oppression including IPV. Informed by their understandings of the often-complex realities of women's lives, workers, Elders, and administrative leaders shared a common goal of explicitly working towards creating opportunities for women to come together in places of physical and emotional safety and comfort:

AL: We were very focused on having safe environments for women because as you know, in our neighbourhood, women are still in such danger and so vulnerable and so unsafe. (P38)

Two Elders involved with AIDPs in different regions of the province shared similar views:

E: I think the program strives really hard to create a safe place for women, right. (P21)

E: You know she [a mother] feels comfortable here and this is a place of being safe and a lot of women have gone through many abuses and now realizing that there are nice places in the world not just whatever you're going through. . . . You hear that this is a trustworthy place and a calm place. (P24)

The following excerpt highlights the importance of creating safe spaces for women, as their decision to engage in a program was often influenced by their vigilance for being judged, and their personal comfort level in a particular socio-environmental context:

M: You walk through the door it doesn't matter who you are or what your circumstances are, there's no judgment. . . . They are really here to help make you comfortable . . . I feel like a piece of the furniture and I make sure in my life wherever I go if I don't feel like a piece of furniture I move on, [laughing] and it was very easy to feel comfortable here and to relate to others and accept their help. (FG2)

The focus of AIDPs in creating safe spaces for women in urban contexts reflects some of the emerging research on the intimate nature of 'urban-indigenous' health care organizations, in which an essential 'relational outcome' is "a place where one feels at home and welcome" (Wendt & Gone, 2012, p. 125). However, these findings also raise questions about the gendered nature of AIDPs and the risk of failing to be responsive to the particular interests, strengths, and priorities of male caregivers. The following perspective is from the one father who participated in this study: "I see other women bring their hubbies or partners or their better half there and they just like look . . . so awkward and out of it because like for a typical guy like that's just not" (P28). Workers agreed that cultural programs, programs that were more action-oriented, and programs that were offered in an evening or weekend tended to attract more male caregivers.

6.1.3 Buffering Women's Experiences of Social Isolation

AIDP workers routinely provided opportunities for women to come together in

group programs with or without their children in attendance⁸⁵. There was agreement amongst the women who participated in this study that being part of an AIDP had helped to buffer their experiences of marginalization and social isolation as they raised their children away from their own childhood communities or home territories:

M: I thought in my isolation that I didn't have any significance just because I was so overwhelmed by society's outlook on me I guess . . . [AIDP] helped me look at me in a different way because people were having the same struggles, were having the same issues, it sort of gave me a sense of belonging and I owned up to that because I started to feel good about myself . . . Just knowing that somebody is acknowledging your existence and that you feel like you're in crisis and it's like that realization you're not alone again because you're part of a group. And the moms are going through the same thing or even worse or whatever it may be. (P26)

An Elder adds to this discussion:

E: I think one of the biggest challenges that the young moms that I work with is that they are by themselves under-valuing themselves. (P21)

Many of the mothers in this study spoke passionately about the friendships, social supports, and sense of belonging they had developed through their participation in groups run by AIDP workers. Group programming provided an important opportunity for women to develop their capacities to nurture well-being in themselves and others in the group through the mutual sharing of advice, practical help, and emotional support. This occurred during the group program and in some cases extended into friendships that carried over to their daily lives:

⁸⁵ Group programs varied greatly between AIDPs and included opportunities for caregivers to develop their skills in particular areas such as budgeting and cooking nutritious food; infant massage, or centered on cultural activities. Group programs also frequently involved caregivers and children together in more social and play-based group programs. AIDPs typically provided daycare for the duration of any adult-only programs.

M: I've been through a lot like losing family members left and right and having like financial problems with money and that and this program and the parents are a big help because they help out with clothes or pull-ups, or groceries and, yeah, stuff what we need and that. And, yeah, that's really a big help and that's why I like this place because we're all here for each other. . . . And we even bump into each other and go for coffee or go for lunch. Or do you need help with this and that and just help each other. When you come here too, everybody has the same problem, you know, it's not a big problem it's a minor problem. (FG2)

Findings suggest that group programming also fostered women's knowledge, agency, and mutual support in relation to raising their children:

M: I became a mother too young so I never knew what I was doing but I kept going through it so it's different with each child. And when I want to ask questions even though I have more kids than some of these other women I still go to them for advice. I'm like oh this is happening, what do I do and because I'm in a panic because this is a different child it's not the same. So it helps with the other mothers around too because they give you advice and you could choose to take it or you could choose to try it or not, it's up to you and it's just them helping you out if they can. (FG2)

These findings emphasize the health-promoting potential of group programs in safeguarding women from the detrimental effects of social marginalization and isolation.

Findings also suggest that being part of a reciprocal social network strengthened women's agency, resistance and 'positive identity formation' (K. Anderson, 2000) as Indigenous mothers raising their children in an urban context.

6.1.4 Fostering Indigenous Knowledges, Identities, and Sense of Belonging

Coming together as a group in many urban-based AIDPs also fostered, as this worker described: "[families'] sense of pride and curiosity and knowledge and connection with their culture" (P38). In their work on 'urban Indigenous therapeutic landscapes' Native American scholars Wendt and Gone (2012), draw attention to how 'a sense of belonging' involves "interpersonal networks of intimacy, familiarity, and shared identity" (2012, p. 1032). Findings suggest that women's sense of belonging within a

socio-cultural network was fostered over time by coming together in caring and supportive relational spaces with other Indigenous family members, Elders, and workers:

M: I think it's important to have the Elders as well as the babies that you had seen. It's sort of like the whole family, it would be really nice to see the father be there too. . . . It comes back to that sense of belonging, you know, everybody has a place and the Elders can share stories. . . . It just sort of adds to the sense of belonging. (P26)

Group programs provided women with opportunities to have a sense of belonging within 'an interpersonal network of shared identity' (Wendt & Gone, 2012), and to (re)connect with their culture:

M:.. with the AIDP, everything was hands on, we made drums, you know, it wasn't just looking at it, something on the wall like an inspiration. . . . We made it and we played on it and it was ours. . . . We did moccasins, rattles . . . Now when we go to a sweat and stuff like that I'll bring out the drums, I'll bring out the rattles and we have things to take to a ceremony now right? [name of worker] reintroduced me and my child to culture by taking us to a Sun Dance like that's something that's important to us, we both got our spirit names there. . . . So her taking me to a Sun Dance I was able to network with other people that were a lot like me, they came from the same background and were recovering right, so that was a really beautiful experience. (P03)

Similar to the challenges faced by urban Indigenous health organizations (Senese & Wilson, 2013; Wendt & Gone, 2012), AIDP workers questioned how to respect and foster the diversity of Indigenous knowledges and identities in urban contexts:

W: A lot of [women] are just moving from their reservations to here. So I was trying to figure out a way of how we can best meet their needs. We ask them if they want to participate in sharing the crafts that they've done, the ceremonies they participated in, what that looked like. And the Elders that we had present during that time, it's a great conversation, a nice way to build a relationship with them for their children. If there's something that they wanted to bring forward and share with us. This is what we did for our ceremony so let me share it with everybody else. This is the type of food we have there. (P02)

In working towards addressing these challenges, many workers had developed lasting relationships with one or more Elders. Elder participation is a key 'indicator of quality' in

Indigenous early childhood programs because they support the transmission of Indigenous knowledge and language (British Columbia Aboriginal Child Care Society, 2014b). Elders played an essential role in sharing their knowledge, values, and beliefs through ceremony, songs, drumming, storytelling, and through teaching activities such as beading, and making baby moccasins or medicine bags. The location of AIDPs within FCs also enhanced families' access to 'different kinds of ceremonies', as described in the following excerpt from an administrative leader of a Friendship Centre:

AL: We've got a really a strong cultural leadership in the organization so we're able to provide supports to families in other ways that mainstream wouldn't be able to do with Indigenous families in terms of different kinds of ceremonies. We have our own wilderness camp so we do family camps, you know, where families can come and we do all kinds of different activities. Out in our camp we have our sacred ground so we have our own sweat lodge; we've got our own spiritual leader who does the sweat lodge ceremonies; does pipe ceremonies; does circles, does a lot of that work around, you know, culture and ceremony and traditions and, you know, I mean we've got our own group of Elders that we host on site. (P37)

The high value families placed on Indigenous knowledges and practices was evident in workers' recognition that providing 'cultural programs' brought families together in ways that prescriptive and imported parenting programs sometimes failed to do:

W: When we have, for example, 'You Make the Difference' parenting program we would get maybe three to five families maybe sign up and . . . then we can say our drum groups which consistently always has a wait list [laughing] and it's always kind of the cultural programs that draw the families that connect the families and I think . . . the more you can keep that as your foundation the more successful the program will be provided the program has the resources to do it. (P07)

R: Why do you think that is such a draw, the cultural component?

W: I think families can identify with those pieces. Like it's more relatable. The cultural programs don't necessarily feel kind of [like] schooling . . . it's more relatable, connecting with them. (P07)

These findings suggest that urban AIDPs are playing an important role, as argued by Peters and Anderson, in “reformulating Western institutions and practices to support Indigenous cultures and identities so that Indigenous people can continue to survive as distinct people(s) in contemporary societies” (2013, p. 8). Findings indicate that fostering a sense of connection, belonging, and identity may be particularly salient for families who are living in urban settings and/or have grown up in families and communities that have been ‘disconnected and dislocated’ by colonization (Stout, 2012).

6.2 Reframing the Early Intervention Process

In the following section, the focus of analysis shifts to the findings that demonstrate how workers enacted their relational accountability in the EI process by adapting and reframing their routine practices. Reframing the EI process was necessary, so that workers could engage families in their programs and be highly responsive to families’ lived realities in ways that contributed towards family well-being and fostered child health equity.

6.2.1 Resisting Normative Program Expectations

As discussed in Chapter Two, mainstream ‘family-centered’ EI programs are frequently underpinned by largely unspoken expectations that caregivers will conform to a predetermined process in which there are tacit assumptions about how to respond and behave (Vacca & Feinberg, 2000). In other words, there is an unspoken expectation that a family will adapt to the program:

W: We’ve heard of the noncompliant families, we’ve heard of hard to reach families. Well maybe they’re hard to reach because we haven’t been willing to move a step forward. (P01)

Failure to conform to expectations can have serious material effects for Indigenous families where labels of being hard to reach, disinterested, or noncompliant may result in increased state surveillance or intervention. In contrast, findings point to how AIDP workers' relational accountability in the EI process served to resist and disrupt normative expectations in order to engage families in their programs:

W: I think that people forget about their place of privilege and they forget how much these families struggle. And sometimes there's sort of that expectation well if you didn't show up for your visit that's it, you know, we're closing the file. But I tend to keep my files open probably longer than say a mainstream program would because I really actively seek out my families to try and get them to engage and get back on board. (P30)

Workers reported putting aside their taken-for-granted practices and embracing a flexible and dynamic approach to EI in order to engage families in their programs. In this way, workers strived to 'make the program fit the family':

W: I mean people say family centered practice but they are sometimes from that child-focused place where the family has to fit the program. We try really hard to make the program fit the family we really do. I know many programs extend themselves but I feel like AIDP does that naturally. (P01)

Workers discussed how engaging families in their AIDPs, routinely involved giving caregivers choices about their participation. Some parents chose to meet workers in a more communal setting such as a playgroup or daycare, or more personally in their homes, a local coffee shop, park, or whilst grocery shopping. Programs also had mechanisms in place for regular feedback from families. As one mother noted: "It's nice for programs to ask you what you want to see instead of them just saying, okay, here you go this is what we're doing . . . that gives us value" (FG2).

Workers also explained how they adapted the temporal flow of their intervention to a pace that was informed by their understandings of families' lives and was responsive

to each family's circumstances and preferences. Rather than rushing in, the pace of AIDPs was described as slower and gentler than the typical linear and fast-paced expectations of their mainstream counterpart programs:

W: With AIDP my sense and consistent I think with Aboriginal values is you let the process unfold as it needs to. And so I would recognize that maybe speech was an issue but it might have been five or six visits down the road that we would actually move to the conversation around . . . possible referrals to say a speech therapist . . . whereas IDP they would move pretty quickly to that, we need this done, here it is. (P07)

Workers also described how families' historical and ongoing experiences of state scrutiny and intervention required a slower and gentler pace of EI:

W: Some of the feedback I've got is that it looks scary to sort of bring a bunch of stuff and start asking all these questions that to me don't sound intrusive because I'm just trying to understand the family and get kind of where they want to go with it. But for a family that's had services, or there's a threat of service, or they know a family member that's had child protection services they feel that it's quite intrusive and bringing paper kind of takes away from that relationship piece. It seems a bit more threatening. (P29)

Findings suggest that workers were particularly attuned to the timing of screening a child's development. Workers recognized that many caregivers perceived developmental screening as a "test, pass and fail and something to be worried about as opposed to helping build on strengths" (P35). Workers described the importance of delaying screening sometimes for several years:

W: Sometimes we have pediatricians who want us to do developmental assessments on them like yesterday. . . . We've had to educate people on what family centered practice is, meeting the family where they're at. We're not going to do an assessment on our first or second visit. (P01)

Underpinning workers' perspectives on the timing of developmental screening was an implicit assumption that this taken-for-granted practice frequently had an adverse impact

on building relationships, and that introducing an assessment too early risked losing a caregiver's trust:

W: Formalized assessment and goal setting intervention kind of approach; it doesn't work, and it doesn't feel authentic for me either because I know the relationships won't thrive like they're not natural. Then I feel like I'm hunting people. (P29)

Another worker adds her perspective: "Sometimes we wouldn't even bring a screening or even go there until we've been with this parent for two years right?" (P06)

These findings point to the importance of workers resisting normative practices and adapting the temporal flow of EI in order to engage families in their programs. A slower pace of intervention also enabled workers to learn from caregivers about their day-to-day lives, and in turn to be responsive to their more immediate concerns and priorities, which is the focus of the following section.

6.2.2 Responding to Caregivers' Agency and Self-identified Priorities

Prevailing EI discourses tend to be underpinned by the central assumption that an individual child's early health and development are the primary concern and focus of EI. A significant finding in this study is how EI was responsive to caregivers' concerns and priorities that often focused on family well-being:

W: Typically a lot of our interventions and a lot of our paperwork is really geared to the progress and supports for the children based on family input, of course. . . . I'm finding just more success for the children if I can somehow advocate actually more for the family whatever that need might be rather than just focusing on the child. (P29)

As discussed in the previous findings chapter, families' lives were frequently constrained by the downstream effects of poverty. In response, workers discussed how they

frequently supported caregivers in accessing basic determinants, particularly food security:

W: Sometimes just even being able to just find milk for their infants and just even thinking about healthy food choices. . . . When they had income coming in they'd be fine but when they'd come to the program certain times of the month, it would be a real struggle. And so sometimes the focus would be just making sure that they have access to food . . . to bring home because they'd be very emotional and couldn't do anything until that was provided. (P06)

Additional ways in which workers were responsive to families' day-to-day lived realities included: helping with housing applications, providing transportation to medical appointments, teaching caregivers how to budget for and prepare healthy affordable meals; and, as discussed in more detail later in this chapter, navigating the health care and child welfare systems. Workers also discussed the challenges of providing the right amount of support in response to a caregiver's agency and circumstances:

W: I had a client the other day who said 'oh I couldn't get to the food bank'. I'm looking at my clock and it's closed now. And she said 'all I really needed was the milk; that was the most important thing'. And I just wanted to go to the store and get a jug of milk and say, 'oh someone donated a jug of milk and here you go'. And I just literally stopped myself. But then after the weekend, she told me 'oh yeah, I talked to my brother, because they're not drinking milk anymore, you know, they had enough'. She worked it out and I know that she can. (FG1)

There was consensus among workers that providing EI that caregivers' experienced as practical and responsive to their immediate concerns and priorities was central to engaging families in their programs. Workers' highly responsive approach was supported through a province-wide AIDP policy that allowed for smaller caseloads, compared to their mainstream counterpart programs:

W: The way that we could adapt was lowering our caseload and so because we needed more time, like some of the families you just have to invest more time and whether it be relationships or connecting them and being that liaison to other resources it all takes time right? I'd keep it between 20 and 25 depending on the

consultant and what they were navigating on their caseload. Whereas I know IDP they're anywhere between 30 and 45. And I can't imagine having that number on my caseload and navigating the social issues that are like pretty much every family that comes through that door has a certain level of social issues that they're trying to navigate. (P07)

These findings provide evidence of how workers' routine practices and policies were responsive to families' realities and circumstances, and strived to mitigate the harmful effects of socio-economic oppression on families' daily lives and well-being.

There was also evidence of how workers' capacity to be responsive to families' strengths and needs was influenced by their host organization. As discussed in Chapter Two, urban AIDPs are typically administered by, and nestled within, large community-based organizations. Workers and administrative leaders frequently used the term 'one-stop-shop' to describe how their organizational structure supported families' access to multiple resources, services, and programs. Workers described how their intra-organizational relationships increased families' access to a broader range of typically siloed adult and children's resources, services, and programs that they may not have otherwise known about or have accessed:

Field note entry: Relationships amongst the staff group and with the clients in this building appeared to be key to the success of AIDP and for women to access services that they otherwise might not have if they were scattered amongst different institutions and locations.

A worker adds her perspective to this discussion:

W: I think there's a very easy transition and programming so it's one of the hubs or 'one-stop-shop' type of model that I think have been very, very successful so.. if you go there for prenatal you also go there for AIDP. You have resources to help you with housing, with food, you have access to Elders and Indigenous cultural activities. You have access to other programming for your older age children that are school age or youth altogether. (P01)

These findings highlight how families' access to a broad range of social and Indigenous determinants of health was enhanced through the co-location of AIDPs within urban-based, multi-service organizational hubs.

6.3 Navigating Systems

Indigenous feminist, Anderson (2000) proposes that many Indigenous women engage in a process of 'identity-formation' that is inextricably linked to the current, historical, and future contexts of their lives. In this section of the chapter, Anderson's (2000) theorizing informs my analysis of how AIDP workers supported women's resistance, agency, and 'positive identity formation' as they navigated the health care and child welfare systems.

6.3.1 Navigating the Health Care System

For the mothers in this study, the health care system represented places in which they had experienced, or anticipated experiencing racism and discrimination. They described encounters with health care providers that were dismissive, judgmental, and in some cases blatantly rude as health care providers were 'just doing my job':

M: Some doctors just put you down too so like Dr. [name], she did after I had one of my children and boy I was ready to freak out and just yell at her and just put all my anger out. . . . [The doctor] was saying that I was doing drugs and alcohol and stuff like that and she was just chucking everything in my face and I was like trying to politely answer questions and then it was just like whoa. . . . Other parents have had bad experiences with her and she's just like well 'I'm just doing my job I have to ask these questions'. I was like well you do it in a rude way and I just told her to stay away from me. (FG2)

AIDP workers from different regions of BC were in agreement that many of the mothers in their programs were extremely reluctant to access, or return to, particular adult and/or

child health care professionals or services because of previous negative and distressing experiences:

W: When she [the mother] went the first time [to the local emergency department] she was told ‘is that even your child’ and like just disrespectful, and then coming to me crying saying can you go with me because I can’t get anywhere.. (FG1)

Navigating the fragmented system to access children’s health and EI therapy services in BC can be difficult for all families. These findings highlight the additional challenges faced by Indigenous women who experience structural violence in the form of racialization and routine dismissal in a health care system that presents as being neither benign nor equitable (Denison et al., 2013; Kurtz et al., 2008; Reading, 2013; Salmon, 2007a).

6.3.1.1 Disrupting Racism and Increasing Health Care Access

Navigating the health care system with families is not a typical feature of their mainstream counterpart, IDPs. In being relationally accountable and responsive to women’s lived realities and self-identified priorities, however, workers routinely supported women in making greater use of the health care system. This form of support was responsive to women’s individual levels of agency, and continued until they felt comfortable in accessing a program, or engaging with a particular health care provider, by themselves. Workers described how their presence during health care encounters provided women with much needed emotional support and served to disrupt overt expressions of racism by health care providers:

W: I had that experience, I went to a specialist appointment and after the appointment she (the mother) said he (the doctor) was totally different because you were there, and he did seem interested in her and ‘oh how long has this been going on’ and just asking more and more questions and probing further. . . . She

noticed a difference and she said he was so different just because you were there like he cared and was interested. (FG1)

Findings indicate that workers' physical presence⁸⁶ resulted in a tacit shift in power dynamics in health care encounters, as health care providers 'self-regulated their explicit biases'⁸⁷ (Dovidio & Fiske, 2012). Workers described how 'being a safe person' in health care encounters supported women in resisting 'negative definitions of being' (K.

Anderson, 2000), and exerting their agency for their children:

W: You kind of become like a safe person for them and it boosts their confidence and it empowers them and I think lots of them just need to know that they have one person in their corner so they can walk into an appointment . . . and go even if you treat me poorly I know I have this person. (FG1)

A mother described her experience of having her AIDP worker with her:

M: It's kind of traumatic for a parent to go through things like that with their children and having another person there that can explain things too if you don't understand it's really like heartwarming for the parent, it helps you keep your parent face and keep your strength for your child. (FG2)

There was agreement amongst workers that 'being a safe person in their corner' was key to enhancing families' access to EI therapy services and programs. Workers described how their relationships with families and local occupational therapists, for example, helped them to bridge the 'social distance' that can frequently exist between EIT professionals and Indigenous families (Gerlach, 2003, 2007). This is evident in the following excerpt:

W: We would connect them to an occupational therapist sometimes or a speech therapist sometimes. They just weren't comfortable [for] the first visit. So us coming and just being there the first time and sometimes we'd be at every single

⁸⁶ It was not apparent in the data how the ethno-cultural identity of workers influenced their perspectives on, or role in, supporting women in health care encounters.

⁸⁷ Explicit biases refer to stereotypes and prejudices that people are aware they hold and can control deliberately and strategically (Dovidio & Fiske, 2012).

visit. Other times a parent wouldn't need us after the first one . . . if they'd built that relationship with that person. . . . Depending on the therapist [we would] explain things to the parent too in a different way. So they'd go to that hour appointment and . . . they'd sort of not understand something, and we'd say well, do you want me to come and I'll bring some toys and we can talk about some of the things that she shared with you and that would just even help too. (P06)

These findings provide a concrete example of how workers mitigated women's experiences of racialization as they sought to access health care for themselves and their children (Denison et al., 2013; Lynam et al., 2012; van Herk et al., 2011b). These findings also demonstrate the important role that workers played in increasing women's access to programs and services for their own and their children's health that they would otherwise likely not have accessed or fully utilized.

6.3.2 Navigating the Child Welfare System

As discussed in Chapter Five, the daily lives of many of the families who accessed AIDPs were impacted by the threat of, or having varying levels of, surveillance and/or intervention from the child welfare system. In response, an increasing focus for AIDP workers was supporting families as they navigated the system and supporting children who were living in state 'care'. In presenting these findings, I am cognizant of acknowledging the critical role of the child welfare system in ensuring the health and safety of all children in BC, and that my analysis was not inclusive of the perspectives of child welfare personnel.

6.3.2.1 Buffering Families from ‘the Ministry’

In response to the increasing number of families with ‘Ministry’⁸⁸ involvement’ being referred to AIDPs, workers stated that they had to become more informed about the child welfare and legal systems in BC. This knowledge enabled workers to build on women’s personal competency and agency in navigating this system:

M: My [AIDP] worker helped me to understand all the court information that I needed . . . because I didn’t understand it. Even reading the instructions it’s like I don’t understand this. (FG2)

Another worker adds to this discussion:

W: I talked to her about what does the Ministry want, what were their expectations? And she said, well, they’re telling me I have to do a group two days a week and I have to do counseling so many days a week. . . . So we worked on getting those things in place so that she could phone the social worker the next day and say, you know what, I’m going with [name of AIDP worker] and I’m going to that group on Tuesday and that’s all taken care of. (P30)

The Representative for Children and Youth (2013) in BC has characterized the child welfare system in this province as ‘confused, unstable, and chaotic’. In navigating this system with families, workers sought to mitigate the trauma of opaque and inconsistent state-mandated requirements that determined whether caregivers would retain, or regain, their rights to raise, or be involved in raising, their children. Findings point to the trauma of a systemic lack of transparency and consistency by an omnipotent bureaucratic structure that has become a seemingly normative and invisible feature of the socio-political landscape in BC that is nonetheless ‘heartbreaking’:

⁸⁸ In this context, ‘Ministry’ is the term participants frequently used to refer to the Ministry of Children and Family Development. As discussed in Chapter Two, this provincial Ministry is responsible for child welfare services in BC.

W: There's no transparency. . . there's no honesty. You know it feels like that and I've got families that have children in care, families have supervised access and families truly believe that oh my baby is coming home soon, my baby is coming home and there may be no intention of returning baby to family. . . . No they're just building a case against that family. . . . And I mean it's heartbreaking for me and they're not my children. (FG3)

In contrast to the perceived lack of transparency within the child welfare system, workers reinforced the importance of being transparent and honest in their relationships and interactions with families, particularly in relation to their professional 'duty to report' any concerns related to their children's safety:

W:I always tell [families] I'm voluntary whatever happens between you and me stays between you and me as long as it's not within something that I have to report. . . . I always say when I have to report something I always talk to the family about why I need to do this. And I ask them to come with me because I always say if you come with me and we say it's because you need some support it will go better. . . and that has always worked. (P27)

In response to how state intervention and oppression played out in families' lives, these findings highlight how workers strived to keep families together and mitigate the trauma of state surveillance and intervention.

6.3.2.2 Providing a Critical Counter Narrative: 'You Are a Good Mom'

The child welfare system has historically "focused on investigating and then addressing parental shortcomings or misconduct" (Hughes, 2013a, p. 30). Workers described their experiences of supporting mothers who 'felt like bad parents' because of their interactions with the child welfare system:

W: I worked with this mom, she was in tears because she told me that the Ministry made her feel bad and made her feel like she was a bad parent and she couldn't do anything right. (P30)

The potential harmful impact on maternal well-being of a systemic discourse that predominately targets ‘parental shortcomings’ is evident in the following mother’s experience of ‘being overwhelmed by society’s outlook’ on her:

M: I think for the most part too [being part of a group program facilitated by her [AIDP worker] made me see myself as an important person because I’m the mom right? And I never sort of established that, or felt good about it because I was a young mom and it was sort of like frowned upon. You’re just another statistic of an Aboriginal woman having kids, multiple kids and you’re never going to get off welfare, never going to sort of amount to anything. It made me look at me in a different way because people were having the same struggles, were having the same issues, it sort of gave me a sense of belonging and I owned up to that because I started to feel good about myself because I thought in my isolation that I didn’t have any significance just because I was so overwhelmed by society’s outlook on me I guess. (P26)

Workers’ strengths-based relational approach provided a critical counter narrative to women’s experiences of being disempowered, judged, and mandated to prove themselves to the state in order to keep, or reclaim their right, to raise their children:

M: I think that’s why AIDP is so important because if . . . you give the mom some encouragement and support her in other realms of her life. It’s like you don’t have to live like this. You have skills, you are important, you are a good mom, you know, not coming from a place from judgment. (P26)

Mothers discussed how they felt safe asking questions and sharing information with workers knowing that workers would not ‘use it against you’. As this mother noted:

M: It’s safe for you to express what you need to express and ask for help. . . because you know, [AIDP workers are] not goanna take it and use it against you or make you feel threatened or anything, they make sure that you feel safe and secure with what you share. (FG2)

Workers described how they supported women in resisting ‘negative definitions of being’ (Anderson, 2000) and asserting their agency as mothers:

W: It’s all about relationship, it’s all about these moms who have never been connected to somebody without feeling judged or having to be something . . . if we can go in and just accept them for who they are right there we’ve done more for

that person than anything else can do because really that's what we all want is to belong and to be accepted and not to be told, okay, like you have to do these million and a half things, the Ministry often does about parenting and I totally get it. But they're never ever being looked at, okay, and they might say, okay, these are your skills but it always comes with a but. (P27)

This form of intervention extended to supporting women who chose to maintain or reclaim their parenting role and identity when their children were in the 'care' of the state on a temporary or long-term basis:

W: [When] the baby was removed from the hospital I was there for that meeting at the hospital. The mom knew because she wasn't healthy enough to have her baby come home with her but in the meantime baby was there for two weeks in the hospital and after the mom was released from the hospital she had to have supervised visits. . . . There wasn't anybody else but me at that point to support her with these visits so I went almost every day for like fourteen days and in the evenings, on a Sunday. . . . and this is extraordinary because normally I don't do that. But this is her baby right and I wanted her to keep that connection and that attachment (FG1).

These findings demonstrate how workers strived to resist the colonial myths of Indigenous women as 'unfit and uncaring mothers' that continue to be legitimized and normalized through their over-surveillance by the child welfare system (Blackstock, 2011; Hughes, 2013a; Pringle, 2010; Representative for Children and Youth, 2013; Sinha et al., 2013a). They also highlight how workers' explicit valuing of women's 'agency, resistance and positive identity formation' (Anderson, 2000) provided a critical counter narrative to historically-constituted and racialized discourses which pathologize Indigenous mothering and legitimize ongoing state intervention (Fiske, 1993; Maxwell, 2014).

6.3.2.3 Advocating for Children in State ‘Care’

Workers’ knowledge on maternal-infant attachment⁸⁹ as foundational to infants’ health and development (Hardy, 2013), informed how they sought to buffer infants and young children from the trauma of being apprehended by the state, and growing up in out-of-home state care on a short-term or permanent basis. Nonetheless, workers consistently reported that, despite their long-term relationships with families, they were frequently not informed or ‘told too late’ when a child was being apprehended. The following excerpt, however, highlights the vital role a worker played when she was informed and able to be present for two children when they were being removed from their biological parents:

W: I had a relationship with the children. . . . But no one was talking to the children. So that was really important to me to be sitting on the floor and saying to the children so what we’re going to do now is we’re going to get some of your things together and we’re going to go in this car which if I wasn’t there who’s talking to the children what’s going to happen? Those children were really confused and in shock. . . but being able to stay with them at the home with the foster parents who just met them and the social worker left. (FG1)

Workers reported being referred an increasing number of children who were living in the foster care system, and described how they strived to connect children with their Indigenous heritage:

W: We’re also working on putting together cultural journals for children. . . . Where was their territory? What was their community like when they were children? Who were their prominent community members? . . . Like a cultural scrapbook and just life book for these little ones especially the ones who are in care who have been disconnected (FG3).

⁸⁹ Some of the workers are taking/have taken extra training through workshops and/or as part of a certificate in infant mental health in order to better understand disrupted mother-infant attachment and its effects on children’s early development.

The important role of workers as children's advocates within the foster care system is further illuminated in the following excerpt from a worker who was referred a three-year old child. This child had been moved between multiple foster homes and had received a medical diagnosis that was being treated with antipsychotic medication when the worker became involved:

W: [This child] has been in [multiple] different [foster] homes, has been abandoned that many times in that short period of life and somehow labeled as sort of having a mental health issue... But I'm like anyone would go through that kind of, you know, like that's not building resiliency at all in children, that's just sort of kind of selling them down the river and seeing they're broken let's put them on medication. . . . That to me is unacceptable practice and that happens quite a bit where we're advocating for children because we haven't done it well as a system. (P29)

What is particularly striking about the above excerpt, is how intervention by this worker disrupted a decontextualized professional discourse in which a child's social suffering and trauma responses were being labeled and 'treated' as mental health or behaviour problems (Haskell & Randall, 2009; Salmon, 2007b). This finding highlights how the 'significant vulnerabilities' that can be experienced by Indigenous children "are compounded by their involvement in the child welfare system" (Representative for Children and Youth, 2013, p. 21).

More broadly, the findings in this section show how workers, in being accountable and responsive to women's self-identified priorities and the contexts of their everyday lives, frequently required them to navigate the health care and child welfare systems. In this way, workers played a key role in increasing families' access to health care, and mitigating the trauma and structural violence of racialization and state-sanctioned child welfare policies and practices.

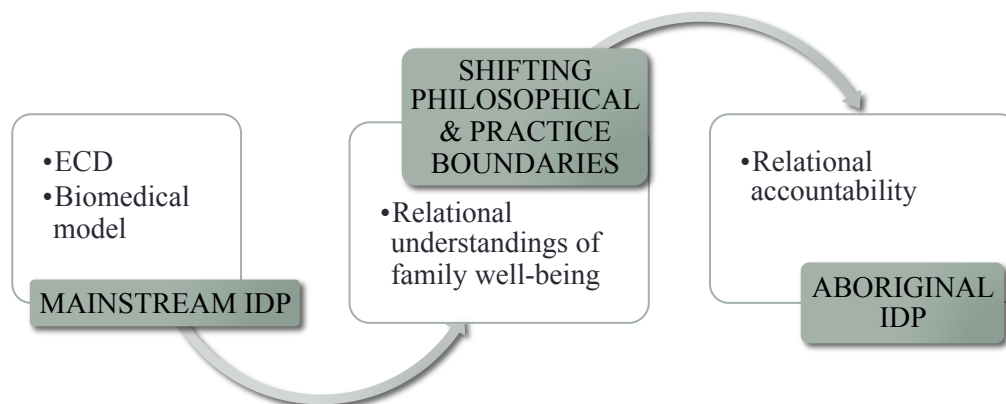
6.4 Traversing the Contested Terrain of Early Intervention and Child Welfare

In this final section of this chapter, analysis shifts to the findings that focus on how workers had to traverse back and forth across the broader EI and child welfare landscape in BC. Findings demonstrate how workers' relational accountability in the EI process, required a shift in philosophical and practice boundaries that created some tensions and challenges as they crossed the contested terrain of EI and ventured into the complex terrain of the child welfare system.

6.4.1 Deferring an 'ECD Agenda'

A significant and recurring theme in the findings is that AIDP workers' relational accountability and pragmatic approach to EI frequently disrupted their a priori ECD knowledge and normative EI practices (Figure 2).

Figure 2: Shifting Philosophical and Practice Boundaries



Routine practices such as asking a family questions about their child's development, completing paperwork, and using a standardized developmental screening tool are hallmarks of EI programs or, as referred to by many of the workers, an 'ECD agenda'. An unexpected finding woven throughout the data was that engaging and building relationships with, and being responsive to, families was frequently predicated on

workers deferring their ECD agenda as they shifted their focus away from children's development:

W: There's certain expectations for maybe doing assessments and things like that but in meeting with the parents in where they're at that might not be their goal right, so, and very often isn't. And when I do bring it up they're like oh well, no, that's okay, you don't need to do that. . . . So how do you just pick one thing? Like we're going to focus on infant development when . . . that's not something that they're struggling with right now. (FG1)

As one worker stated: "If I'm on my agenda it just doesn't work well" (P29). Workers discussed how more child-focused forms of intervention were deferred until the timing was right for each family. As a worker noted: "You do get to get back to your child developmental milestones when you finish dealing with other areas of the family's lives" (P01).

Workers conscious deferral of their ECD agenda resulted in a radical shift in the focus of EI as caregivers' agency, priorities, and concerns were given primacy and legitimacy over workers' professional allegiance to child-focused intervention. Findings indicate that for some workers, shifting the focus of their intervention away from the needs of a child, who they perceived could potentially benefit from timelier EI, frequently caused them to question their practices:

W: I am finding it hard because. . . . I would like some help for this child in this area and I'd really like to help support the parent to see this but they're not ready to see this. And that probably tugs on my heart a little bit because I want that child to be . . . healthy and developing. . . . So it is a really big like tension. (FG1)

Whilst workers expressed their uncertainty in deferring more child-focused intervention, there was also a sense that this was central to workers' ability to be morally and socially responsive to the often-complex realities of the families who accessed their programs:

W: It's about Maslow's hierarchy. . . . For me to even talk about a child's speech delay when they might not even have housing at the end of December, they don't care and it's impossible to ask a family to do something about infant development if they're worried about where their next meal is going to come from. (FG3)

Ironically, these findings highlight how workers not only deferred, but frequently went beyond, their 'ECD agenda'. This included for example: a worker using her own vehicle to help a family move to a new apartment over a weekend, visiting a mother in hospital despite the fact that she was no longer in their program, and being present in the delivery room with a mother who had no one else there to support her.

6.4.2 Working 'in the Grey Zone'

The underlying philosophy and practices of AIDPs are not currently well represented in ECD literature or discourses. AIDP workers reported that they had to "listen and think differently" (P29), and practice in ways that were often distinct from their prior ECD education and experiences. Findings indicate that some AIDP workers frequently felt overwhelmed because they were 'called on to be many things for families' and were 'always working in the grey zone':

W: You know when you open that door [for a home visit] you have no clue what's on the other side. . . . We're always in the grey zone right? And questioning ourselves. . . . Someone said what do you do? She goes, well your work is kind of grey isn't it? I said yeah . . . I can't define it. . . . I feel overwhelmed a lot of the time because often I'll sit there on a visit, I'm going I'm an early childhood educator, how did I get to this [laughter] you know. What am I doing here? (FG1)

Working with the ambiguity and complexity inherent to authentically 'meeting families where they're at' frequently involved workers going out of their ECD comfort zone and trying something despite not knowing if it was going to work:

W: I feel like half the time I am swimming upstream sometimes and I don't know what I'm doing, but I'm hoping something works right? Like it's just kind of in that moment, it's kind of like, okay, what will work today, what can I do today?

These are my goals and her goals and how can I meet these today? Sometimes I don't know. Sometimes things I do fail, you know terribly, and some of them we have to try something else. . . . And then you can honestly say, okay, well that didn't work we're not going to do that again right? (P27)

Workers' described being emotionally engaged in, and affected by, their relationships and experiences with families. Workers also expressed their concerns that the personal and multifaceted nature of their relationships with families, challenged their preconceived ideas of what constituted normative professional boundaries:

W: [I am] trying not to get personally involved and a person said but you are personally involved . . . because you know, what's going on for them and you know what's going on for their children and they are putting that trust in you. (FG1)

In working in the grey zone within the broader ECD landscape, workers also described feeling 'judged and undervalued' by 'mainstream therapists or other professionals'. As described by this worker:

W: In the beginning we had to kind of be secretive that [we] would give our parents food . . . because we would get judged and we'd be told by other people that, well, you can't do that. . . . I just feel so undervalued and always judged when I'm at a kind of like a case review meeting where there's mainstream therapists or other professionals there and always having to kind of explain why I'm doing this and, yet, if I was to turn around and ask those same questions I would be considered uncooperative. (P07)

Another worker shares a similar perspective:

W: I do assessments on kids. . . and it's all good to set goals but you know what? Every frigging goal I've ever set, I went in the next day I'm not doing that [laughter]. And I've heard so much from IDPs how we don't, and I don't know what makes them elite? Is it because they have this neat little file. . . . I don't know because I've kind of wondered. (P27)

These findings suggest an implicit 'hierarchy of subjects and knowledges' (Gandhi, 1998) within the wider ECD landscape in BC, in which AIDPs appeared to lack the legitimacy of their mainstream counterpart programs. This was further compounded

by the nature of the monthly statistical information, SIRF⁹⁰ required by their provincial funding agency, the MCFD. This reporting system was developed for mainstream IDPs and included: the number of children receiving individual attention and the hours of individual intervention per child. This system often failed to capture what AIDP workers were ‘actually doing’, as this worker describes:

W: I keep saying that we need to change our stat template because it’s not reflecting fifty to sixty percent of what we do. (FG3)

Workers reported the challenges of providing a time and cost intensive home-visiting and outreach model of EI, relative to centre-based programs, when their organizational leadership did not recognize the value of a home-visiting program:

W: Not all directors or managers understand early childhood development. So they’ll look at it from a very business place, very outcome measure based, very numbers based and sometimes it’s difficult for them to see the value in a program that only visits one family at a time. . . . They kind of see the numbers versus, you know, the work that is done one-on-one. (P01)

These findings indicate that how AIDPs have innovated and evolved away from their mainstream roots was misunderstood and perceived at times as lacking validity and legitimacy within the broader ECD community in BC. Although workers voiced their concerns about working in the grey zone, that is ‘walking in that space between knowing/not knowing’, and navigating ambiguity in their routine practices, this approach is increasingly recognized in the literature on relationality as being central to promoting individuals and families’ health and well-being (Hartrick Doane & Varcoe, 2015).

⁹⁰ ‘SIRF’ stands for: ‘Service Indicator Reporting Framework’.

6.4.3 Being ‘Constantly Pulled to the West’: Developmental Screening

Findings also demonstrate the challenges and tensions experienced by workers as they navigated between their relational understandings of family health and well-being and the “constant pull to the West” (W07), as described by one worker, of prevailing ECD knowledge and EI practices. This was particularly evident in how workers were expected to use standardized tools to screen and report on children’s development:

W: [Developmental screening] almost takes away from the ability to really just observe and engage and . . . leave all that stuff behind without an agenda, without a . . . lens. You just go in, and just . . . get to know the whole child in a more natural way. And I keep going back to how the Elders . . . would connect that person with somebody who could continue to grow that strength. . . . So it sounds like okay, we’ll connect you with what your strength is. For us right now in our role it’s like, okay, your weakness is, we’re going to connect you with. (P35)

This finding raises the question of whether workers’ reluctance to more formally document their relational understandings of children’s health and well-being in their written reports reflected their tacit concerns about their current lack of validity or credibility within the mainstream ECD community in BC. The following excerpt, however, highlights how one worker had started to question and explore how to integrate and represent a more ‘holistic’ view of children’s development in her program’s referral and reporting procedures with child welfare social workers:

W: We are seeing children’s development in a more holistic approach, including looking at how their spirit is nurtured; how they are connected to nature; family, and community. . . . I would like to maybe include some parts on our referral form, that the social worker have to gather information when they refer to us, about the child and his/her family, and the community that they come from. Just so we have some of that background. And the other piece is how can I include in our reports to the social workers really important pieces around that child’s’ culture and development, and how can we make a report reflect that so they start to see that piece? (P35)

Workers reported that the screening tool they used most frequently was the ‘Ages and Stages Questionnaire’, or the ASQ⁹¹ (Brookes Publishing Co., 2012). Although the ASQ has not been standardized with an Indigenous population, workers reported that its use was promoted by MCFD. The use of developmental screening was also promoted by child welfare social workers because they frequently asked workers to provide a written report on children’s developmental milestones.

The findings in this section highlight the tensions and challenges for workers as their relational orientation to EI had resulted in deferring the child-focused individualism of mainstream programs and working out of their ECD comfort zone. As earlier discussed in this chapter, in responding to the realities of families’ lives, workers also had to navigate the child welfare system. The complexity of the relationship between AIDPs and the child welfare system is the focus of the final section of this chapter.

6.4.4 Venturing into Complex Territory: AIDPs and the Child Welfare System

In BC the same provincial Ministry, MCFD, is responsible for the governance of the child welfare system and ECD and intervention programs, including AIDPs. Embedded throughout the findings are ways in which the EI process was shaped by the hegemony of state-sanctioned policies and practices of surveillance that were so pervasive workers found them difficult to resist. Findings indicate that the voluntary nature of AIDPs was being increasingly curbed because caregivers were being mandated, by their social workers, to participate in an AIDP. In this context, workers described how the child welfare system exerted its control over their programs:

⁹¹ The ASQ is an American standardized developmental screening tool that looks at a child’s development in the domains of communication, gross motor, fine motor, and problem solving.

W: Sometimes the social workers do pressure the family to be part of it [the program] because they can see that it would meet maybe some goals that they have or whatever. But because it's coming from the social worker they feel they should say yes. But then to follow through with them [the family] and have conversations with them on the phone they don't necessarily call you back because they don't want to. (FG1)

Workers also stated that they were being frequently asked to report back to social workers on parents' participation in their programs and/or children's health and development:

W: Often it's highly suggested from social workers. . . that parents have a part in our program and I know for me that's a bit of struggle because. . . they're not participating, like if the parents aren't on board. . . and we have to tell the social worker if they decline, and so then they get their hands slapped for not participating right. (FG3)

Workers' expressed their concerns about 'reporting back to the Ministry' and having closer relationships with social workers in the child welfare system. This tension was linked to workers' understandings of the historical context of state intervention in families' lives and how closer ties with child welfare could impact their ability to engage families in their programs:

W: We worked really hard at being in contact with the social workers regularly . . . but I think you have to maintain a certain distance because . . . you have to remember the history our families have with MCFD and it's not a trusting place. These people [social workers] are not trusting regardless of who they are and where they've come from. They work for the institution that has removed many of their kids, and so you have to maintain an arm's length. (P07)

These findings shed new light on how families' participation in AIDPs was being increasingly 'recommended' or mandated by child welfare social workers. These findings raise concerns, particularly given the socio-historical context of state intervention in families' lives, that the growing close relationship between AIDPs and the child welfare

system increases the likelihood that families will be more suspicious and/or reluctant to voluntarily participate or fully engage in their programs.

6.4.4.1 Eroding the Potential for ‘Early Prevention’

As discussed in Chapter Two, the child welfare system has historically largely ignored the role of prevention in promoting the health and well-being of vulnerable children (Hughes, 2013a; Pringle, 2010; Tait et al., 2013). A recent commission inquiry into the death of Phoenix Sinclair in Manitoba concluded that: “prevention is, in fact, the first step on a continuum of protection. Including ‘targeted intervention’ for particularly vulnerable populations” (Hughes, 2013b, p. 458). AIDP workers appeared to be ideally positioned, particularly when they were highly visible and trusted within a community, to play an important role in providing proactive and timely intervention to prevent families from coming under the ‘Ministry radar’:

M: I think [home visits] are sort of vital to this program. . . simply because it’s sort of gauges where the baby is at and if there are any sort of health concerns that the mother can get supports or look at it in a more detailed way. Because if she’s feeling concerned but doesn’t know how to voice, or like I met a mom. . .she was all of 17 with a four month old, and it was like no family, no anything.. and she’s got this baby and there’s a health issue sort of that comes up, [the AIDP worker] can sort of engage well how are going to take care of this or how to go about it or so on. (P26)

Findings suggest, however, that the current potential of AIDPs to prevent families from becoming ‘Ministry involved’ was overshadowed and constrained by families frequently being referred too late, and perhaps more significantly, by workers’ caseloads being overwhelmed by the burgeoning number of referrals to their programs directly from child welfare social workers:

W: This year is the worst year I’ve had for families involved. You know usually before it would be like not even half but now it’s like 94% - 96% of my families are involved with the Ministry. (P27)

Workers described being drawn into a reactive system of state-sanctioned surveillance and intervention:

W: It was always in that crisis state rather than that prevention state . . . and it spiked in the last few years. It's not improving which is what bothers me because I know AIDP has that opportunity to do that. (P07)

These findings raise serious concerns that the increasing rates of referrals to AIDPs from the child welfare system are eroding the potential of these programs to provide EI for families who are not 'Ministry involved'. Furthermore, the increasing relationship between AIDPs and the child welfare system has evolved without any dialogue at a provincial level. The structural erosion of AIDPs to provide early preventative forms of intervention to families that are not Ministry involved is a serious concern that was shared with the CRP during the preliminary analysis of these findings. The CRP was surprised at the percentage of families' with Ministry involvement on AIDP workers' caseloads⁹² and also concerned that the voluntary nature of their programs was being eroded.

More broadly, these findings raise concerns that how AIDP workers provide EI is being shaped by their increasing relationship with the child welfare system, which has a very different perspective of ECD compared to workers' relational orientation. These findings also raise concerns that workers are being unintentionally and tacitly pulled into participating in mechanisms of surveillance and intervention that facilitate the state to 'govern' families' lives 'from a distance' (Larner, 2000).

⁹² After data collection, I requested workers who had participated in this study to provide an estimate of the number of families with Ministry involvement currently on their caseload. Workers do not currently track these numbers, but their estimates ranged from 50-90%.

6.5 Chapter Summary

The findings in this chapter illustrate how AIDPs influenced families and children's health and well-being and worked towards fostering child health equity. Workers' relational accountability in the EI process was evident in the multifaceted ways in which they responded to the structural and contextual nature of families and children's lives. Relational accountability in EI was characterized by: contextually tailored programs for urban contexts, a critical reframing of the EI process, and advocacy and support for women and their children as they navigated the health and child welfare systems. From this perspective, EI was a complex, nonlinear, and dynamic process infused with 'respect, reciprocity, and responsibility' (Wilson, 2008). In addition, the ways in which workers attenuated their power, built on caregivers' agency, and took into account the socio-historical contexts of families' lives are well aligned with the conceptual underpinnings of cultural safety (Gerlach, 2012) and trauma- and violence-informed care (Browne et al., 2012). These findings also illustrate how workers' experienced professional tensions and challenges in their relationships within the broader ECD landscape, their provincial funding agency, and the child welfare system.

CHAPTER 7: DISCUSSION AND IMPLICATIONS OF FINDINGS

In this final chapter, I discuss the implications of the key findings from this research and how they extend, align, or contrast with current evidence and literature. This discussion provides a foregrounding for recommendations and future research.

Concluding comments close this dissertation.

7.1 Promoting Family Well-Being and Fostering Child Health Equity

The discourse on the biologically embedded nature of early adversity in early childhood continues to garner international interest (Bell et al., 2013; Marmot, Allen, Bell, Bloomer, & Goldblatt, 2012; Siddiqi et al., 2011). This scholarship also draws much needed attention to the need for governments to invest in a comprehensive range of early childhood programs, particularly for children who are growing up in conditions of social disadvantage (Shonkoff, 2012). However, there is a tendency for this literature to focus on locating ‘risks’ at the level of individual children, and the responsibility for change and resiliency at the level of individual parents, particularly mothers (Chen et al., 2011; Miller et al., 2011; Monk et al., 2012). These individualistic analyses are in contrast to a relational orientation to Indigenous children’s early childhood, which emphasizes family well-being as a foundational determinant of health, and the inseparable and complex relationship between the social contexts of families’ lives and their children’s current and future health, well-being, and life opportunities (Greenwood & de Leeuw, 2012; Irvine, 2009; Reading & Wien, 2013). This relational orientation is well-aligned with Indigenous perspectives on health and well-being (Hovey et al., 2014; Kirmayer et al., 2009). This critical perspective of children’s health is significant because it disrupts the often

decontextualized and ahistorical child-focused individualism of prevailing ECD discourses (Niles & Byers, 2008; Viruru, 2005), and reduces the tendency for structurally rooted social disadvantages to become pathologized at the level of Indigenous children, or used to discursively ‘blame and shame’ Indigenous mothers (Salmon, 2007b).

7.1.1 Broadening the Scope of Early Intervention

Although AIDP workers described their programs as ‘family-centered’, the findings of this study raise questions as to whether this ‘mantra’ of early childhood programs (Vacca & Feinberg, 2000), represents, or does justice to, workers’ distinct relational reorientation to EI. This inquiry shows how AIDPs workers have built on and extended their mainstream roots, as their relational understandings of family well-being expanded the scope of their intervention. This shift, which was necessary in order to engage families in their programs, generated a nuanced and pragmatic form of EI. The socially-rooted nature of health inequities affecting Indigenous children also required workers to tacitly reframe their intervention to be broad, multifaceted, and socially responsive.

A particularly salient finding is how workers relational accountability to families frequently resulted in the EI process being shaped by, and responsive to, caregivers’ self-identified concerns, priorities, and realities. These foci frequently superseded workers’ accountability to their ‘ECD agenda’. These findings extend our understanding of the importance of having a flexible model of program delivery that allowed workers to contextually tailor and reframe the EI process (Astuto & Allen, 2009; Daro, 2006). Rather than a one-size-fits-all approach, this research illustrates how engaging communities and families in EI required workers to adapt their programs in response to

the social, historical, cultural, economic and geographical contexts of families' lives and the communities in which they were raising their children. This socially responsive form of EI required workers to traverse and bridge typically siloed institutional and disciplinary boundaries that included maternal-infant health, child welfare, and family support services. This finding is particularly salient, given the fragmented nature of programs supporting Indigenous children's 'early years' in BC (British Columbia Aboriginal Child Care Society, 2014a).

From a critical perspective, the ways in which AIDP workers provided EI represents a counter-hegemonic activity because they have evolved beyond dominant early childhood discourses and scope of practice (Dahlberg et al., 2006), including a prevailing neoliberal agenda of school readiness (Press & Skattebol, 2007). AIDP workers' approach to program delivery was also in stark contrast to the prescriptive and educational approach to EI home visiting programs currently being provided for Native American families in parts of the US (A. Barlow et al., 2013; Great Kids Inc, 2014), and making their way into the Canadian early childhood landscape (Healthy Child Manitoba Office, 2010). AIDP workers' approach was also in contrast to EIT programs in which occupational therapists, for example, often implicitly expect families to adapt to their model of 'family-centered' program delivery (Vacca & Feinberg, 2000).

Having a broader scope of practice came with challenges for AIDP workers, particularly when their energy and attention was focused on addressing basic determinants of health or navigating the child welfare system. Supporting family well-being in this way was a fundamental and often time-consuming first step in a continuum of foci in the EI process. A paradox in providing this form of socially responsive EI is

that it was frequently associated with workers deferring intervention focused on children's health and development. The implication may be that Indigenous children with developmental delays or health concerns sometimes have delayed access to proactive intervention at a time in their lives when it could have the most impact.

Workers frequently perceived the broader scope and socially responsive nature of their intervention as 'working in the grey zone'. This finding is consistent with the experiences of workers in urban early childhood programs in BC, that support families who experience multifaceted forms of marginalization (Lynam et al., 2010). This finding is also similar to an Australian study involving early childhood workers who supported Indigenous families "in ways that were often outside their expertise" (Grace & Trudgett, 2012, p. 16). This study identified the need for early childhood workers to have training to better support Indigenous families and children who experienced trauma and/or IPV, and to increase their knowledge of local health care and child welfare services (Grace & Trudgett, 2012). Similarly the findings in this dissertation research, point to the need for Indigenous-specific ECD educational and professional development programs to recognize and support a broader relational perspective of family well-being and scope of practice.

In addition, workers' broader scope of practice and the specific ways in which they supported families was neither recognized nor captured in the 'monthly stats' (SIRF⁹³), required of each program by their funding agency, the MCFD. The erasure of workers' scope of practice through government reporting procedures, tends to devalue

⁹³ As previously discussed SIRF refers to 'Service Indicator Reporting Framework'.

how AIDP workers extended their professional boundaries in order to provide EI in ways that supported family well-being and fostered child health equity. This reporting procedure, because it was developed originally for IDPs, also served to maintain the centering of dominant perspectives on early childhood and EI.

7.1.2 A Trauma- and Violence-Informed Approach

For many of the mothers in this study, EI during pregnancy and early parenting represented an opportunity to ‘turn around’ the effects of intergenerational trauma on their children’s lives (D. Smith et al., 2005). This study highlights how workers were informed of, and responsive to the multifaceted ways in which caregivers’ experiences of intergenerational trauma were often interwoven with stress, trauma, and structural violence in their everyday lives. AIDP workers supported women’s agency, resistance, and positive identity in their mothering roles, as they navigated everyday structural violence in the form of racialization, and systematic dismissal and discrimination in their encounters with mainstream institutions.

Structural violence is a relatively new concept that has yet to be applied in the context of Indigenous early childhood programs. This study provides evidence for framing the EI provided by AIDP workers as ‘trauma- and violence-informed’. Framing their EI in this way may be helpful in distinguishing a key characteristic of AIDPs. The intentional inclusion of ‘violence’ may also disrupt AIDP workers’ tendency to locate trauma primarily at the individual level, and provoke more nuanced understandings of how interpersonal experiences of trauma and violence can be compounded by, or continuous with, structural forms of violence such as poverty and racialization (Varcoe, Browne, & Cender, 2014). However, while the language of structural violence, and

trauma- and violence-informed care, is useful in some contexts (Browne et al., 2012), caution is warranted to avoid perpetuating pathologizing discourses in relation to Indigenous families and children (Maxwell, 2014).

7.1.3 Cultural Safety in Early Intervention

This research contributes to the evidence-informed literature on cultural safety in the context of early childhood programs for Indigenous families and children in Canada. The ways in which workers' privileged families' experiences and the social contexts of their lives as valid and essential forms of knowledge to inform the EI process, and how workers routinely adapted the pace and nature of their intervention to promote a more equitable distribution of power, exemplify practices that are congruent with the conceptual underpinnings of cultural safety (Gerlach, 2007, 2012; Ramsden, 1993, 2005). These findings also extend our understanding on the centrality of family and community relationships to the success of early childhood programs serving Indigenous families and children (Gerlach, 2007; Grace & Trudgett, 2012; Greenwood & de Leeuw, 2012; Guilfoyle et al., 2010; Lee-Hammond, 2013; Nelson & Allison, 2007).

The active involvement of Elders, and the centering of Indigenous ways of knowing, being, and doing in the EI process are supported by international scholarship that identifies 'culturally strong' early childhood programs that serve the 'whole family' as being effective in engaging Indigenous families in their programs (Greenwood & de Leeuw, 2007; Guilfoyle et al., 2010; Priest, Mackean, Davis, Briggs, & Waters, 2012a; Rodríguez de France et al., 2007). According to Durie and colleagues (2009), "cultural identity depends not only on access to culture and heritage but also on opportunities for cultural expression and cultural endorsement within society's institutions. Identity, as

understood within an Indigenous context, is to a large extent a collective experience” (p. 39). AIDPs, particularly when they were located within Indigenous organizations such as Friendship Centers, provided much needed opportunities for families to come together and freely engage with, and express positive cultural identities within safe urban spaces (Wendt & Gone, 2012). These findings are particularly important in urban contexts, given the challenges described in the literature on preserving Indigenous cultures within urban populations (Peters & Anderson, 2013; Priest et al., 2012a; Wendt & Gone, 2012).

7.1.4 Nestling AIDPs in Multiservice Organizational Hubs

Workers and administrative leaders repeatedly used the phrase ‘one stop shop’ to describe organizational structures that provided families with a single access point, or community hub, to multiple resources, services, and programs. This study extends our understanding of how AIDP workers relationships within host organizations that provided a wide range of health, social, cultural, and family support programs and services, contributed towards promoting family well-being in its broadest sense (Ball, 2005b; First Call: BC Child and Youth Advocacy Coalition, 2008; Health Council of Canada, 2011; Hughes, 2013a; Lee-Hammond, 2013). Caregivers’ relationships with their AIDP workers frequently acted as a ‘gateway’ to a broad range of adult and children’s health care programs and services that they may not have otherwise accessed.

The importance of creating community hubs is supported by a recommendation made by Hughes in the Phoenix Sinclair Inquiry (2013). Hughes (2013) called for improving the health and safety of Indigenous children by integrating the delivery of early childhood programs in ‘neighbourhood centers’ where families feel welcome, safe, and can access the services they need. This finding is also consistent with growing

national and international calls for governments to support an integrated, intersectoral, and collaborative approach to a comprehensive range of programs, including prenatal, maternal health, and early childhood programs, in order to meet the often complex needs of all families who experience varying forms of social disadvantage and marginalization (Blackburn et al., 2013; Dietrich-Leurer et al., 2013; First Call: BC Child and Youth Advocacy Coalition, 2008; Hughes, 2013a; Lee-Hammond, 2013; Lynam et al., 2010; Raphael, 2010).

Overall, how AIDP workers have reframed and broadened the EI process suggests that it has the potential to play an important role in disrupting the increasingly defined pathways that link children's experiences of adversity in their early formative years and their subsequent higher risk of health inequities in later childhood and across their life course (Chen et al., 2011; Miller et al., 2011; Monk et al., 2012; Shonkoff, 2012). The ways in which AIDPs influenced family well-being and fostered children's health equity, is consistent with a wide range of interdisciplinary literature and extends our knowledge on: (a) effective interventions to reduce health inequities affecting children living in conditions of social disadvantage (Bell et al., 2013; Morrison et al., 2014); (b) national and international scholarship on early childhood programs for families who experience social marginalization (All Party Parliamentary Sure Start Group, 2013; Bell et al., 2013; Cottam, 2011; Korfmacher, Green, Spellmann, & Thornburg, 2007; Lynam et al., 2012; Pordes-Bowers, Strelitz, Allen, & Donkin, 2012); (c) 'promising practices' for strengthening Indigenous families who are living in urban contexts, (Health Council of Canada, 2011; Neudorf et al., 2012; Scott, 2012), and (d) programs for Indigenous and non-Indigenous pregnant or early parenting women who use substances (Leslie, 2007,

2011; Nathoo et al., 2013; Poole, 2007). Paradoxically, although AIDP practices are aligned with promising practices in these areas, the findings suggest that some mainstream early childhood workers and managers continue to question AIDP workers' credibility within the broader ECD landscape in BC.

7.1.5 Political Action to Support Family Well-Being

This study draws attention to the inseparability between family well-being and child health equity. Consistent with recommendations from the WHO (2013) on 'closing the health equity gap', the findings of this research highlight that it is imperative for governments to address the underlying structural inequities that give rise to conditions of social disadvantage for Indigenous families and create child health inequities. Fostering Indigenous children's health equity is not viable without also promoting a political agenda of social justice and health equity for Indigenous women. These findings support the call for comprehensive social and economic policies that address 'the feminization of poverty' (Mukherjee et al., 2011; World Health Organization, 2013b) and support 'the important work of mothering' (Representative for Children and Youth, 2014). For example, provincial legislation to support affordable and safe child care (First Call: BC Child and Youth Advocacy Coalition, 2014). In addition, this study provides further evidence for radical changes to the child welfare system to recognize and address the historical and socio-economic contexts of families' lives, and the need for preventative forms of intervention so that fewer Indigenous children are removed from their families (Hughes, 2013a; Representative for Children and Youth, 2014; Tait et al., 2013; Truth and Reconciliation Commission of Canada, 2015). This research also calls for the distinct

ways in which AIDPs provide EI to be better understood and supported by their provincial funding agency, the MCFD.

7.2 A Complex Relationship: AIDPs and the Child Welfare System

This study provides insights into Indigenous women's experiences of being 'regulated, disciplined and governed' by the 'blunt instrument' of the child welfare system (Wells, 2009). Findings suggest that the contemporary child welfare system in BC perpetuates structural violence that has become a seemingly normative part of many Indigenous families' daily lives. These findings support the argument that the structure, and 'protection first' agenda of the child welfare system, is failing many Indigenous families and children in BC and across Canada (Hughes, 2013a; Lafrance & Bastien, 2007; Representative for Children and Youth, 2013; Sinha et al., 2011; Tait et al., 2013). The prevalent practice of removing children from their families is of grave concern when families' impoverished living conditions are misconstrued by the child welfare system as willful neglect (Bywaters, Brady, Sparks, & Bos, 2014; Sinha et al., 2013a).

Given this context, it is troubling but perhaps not surprising that child welfare social workers are mandating an increasing number of caregivers to participate in AIDPs. Indigenous children who are growing up in the foster care system are also being referred to AIDPs. In response, AIDP workers have had to become knowledgeable about the child welfare system in order to support caregivers in retaining or regaining their rights to raise their children. While the families that are mandated to participate in AIDPs may benefit from EI, central tenets of these programs, such as their voluntary nature and support of caregivers' agency, are devalued and threatened through their growing affiliation with the child welfare system. Simultaneously, there are renewed provincial and national calls for

earlier and more proactive forms of EI in order to build on Indigenous families' strengths and avoid state surveillance and intervention (Hughes, 2013a; Pringle, 2010; Representative for Children and Youth, 2013; Truth and Reconciliation Commission of Canada, 2015). AIDPs appear to be ideally positioned to provide this EI. However, their availability and accessibility for families that are not Ministry involved is at risk of becoming increasingly constrained because AIDP workers' caseloads are increasingly full of families referred by the child welfare system. In addition, their closer affiliation with 'the Ministry' may lead some families to feel reluctant to *choose* to participate in their programs. This raises serious concerns about the potential for AIDPs to promote family well-being and foster child health equity for *all* Indigenous families in BC.

7.3 Transforming Early Intervention Therapy

The knowledge generated by this study is highly relevant for EI occupational therapists, speech language pathologists, and physiotherapists who are questioning how to improve their services and programs for Indigenous families and children in BC (J. Gordon, personal communication, November 15, 2010). This research provides evidence of the important role that AIDP workers played in increasing families' access to EI therapists, mitigating the added stress EIT can entail for families, and increasing the effectiveness of therapy consultations. This study also provides much needed evidence and justification for EI therapists spending time developing long-term relationships with and learning *from* families, AIDP workers, Elders, and community stakeholders. This evidence indicates that increasing families' access to, and utilization of, EIT requires that these programs and services need to have a much greater visible presence in, and

relationship with, community organizations where families are already gathering and feeling safe.

7.3.1 Informing Occupational Therapy and Occupational Science

In responding to ‘diversity’, occupational therapists, and other rehabilitation disciplines such as physiotherapy, continue to gravitate towards a ‘cultural competency’ lens that fails to take into account how peoples’ daily lives and health are shaped by broader social and structural factors (Heien, 2012; O’Shaughnessy & Tilki, 2007; Wray & Mortenson, 2011). As discussed in Chapter Two, in the context of occupational therapy with Indigenous peoples, there has been slow but growing international interest in cultural safety (Gerlach, 2012; Gerlach et al., 2014b; Hopkirk & Wilson, 2014). The findings of this study extend our understanding on, and further validate the centrality of, relationships to the provision of culturally safe and meaningful occupational therapy for Indigenous families and children (Gerlach, 2007; Gerlach et al., 2014b). The findings also provide much needed evidence on the pace and timing of occupational therapy service delivery and add to our understanding regarding the importance of the socio-environmental context in which occupational therapy for Indigenous families takes place (Nelson & Allison, 2007; Nelson et al., 2011). The relational perspective of family well-being, discussed in the findings, challenges occupational therapists to extend the focus of EI beyond the level of individual children to consider occupations at the level of the family as a more meaningful and responsive entry point for intervention. Taking into account family occupations is in contrast to the typical child-focused nature of occupational therapy intervention (DeGrace, 2003).

From a critical occupational science perspective, a reorientation to relational understandings of family well-being draws attention to how occupations are shaped by broader contextual factors and structural inequities that may otherwise remain obscured. For example, this research shows how taken-for-granted everyday family occupations, such as mother-infant play, were shaped by structural factors, specifically intergenerational trauma from the residential school system (Gerlach et al., 2014a). In addition, this study highlights how the occupation of mothering in the historical and contemporary contexts of Indigenous women's lives can be both a site of resistance and of neocolonial oppression and structural violence. Finally, this study emphasizes the importance of drawing on critical and intersectional theoretical perspectives in occupational science in order to: (a) disrupt normative assumptions about occupations; (b) broaden our understanding of the complexities of occupations and how they are shaped by multifaceted social and structural factors; (c) critically reflect on how our relationships with Indigenous families are irretrievably constituted through historical relations between Indigenous peoples and the state, and (d) inform occupational therapy that is responsive to the lived realities of people who experience marginalization and health inequities (Gerlach, 2015; Gerlach et al., 2014a; Laliberte Rudman, 2013).

7.4 Recommendations Arising from this Study

The following recommendations have been deliberately made as concise and concrete as possible so that they can be readily accessed and applied.

7.4.1 Recommendations for the AIDP Leadership

The evidence of this research will be shared with the AIDP leadership⁹⁴ so that they can determine how this evidence can be used in ways that benefit Indigenous communities, families, and children in BC. The recommendations I will be offering to the leadership include:

1. Following the lead of one program, for AIDPs to be renamed: ‘Aboriginal Family and Infant Development Programs’, or an alternative that reflects the programs’ distinct orientation to family well-being.
2. For the evidence from this research to be used by the AIDP Provincial Office to more explicitly name and frame the distinct ways in which their programs promote family well-being and foster child health equity, including using this evidence in their ‘AIDP Manual’, upcoming strategic planning, workers’ contracts, and promotional materials.
3. For AIDP workers to include a broad perspective of family well-being in written progress reports on children’s development.
4. For the AIDP leadership to collect data on the number of families and children on each worker’s caseload that: (a) have been mandated to attend by a child welfare social worker; or (b) have some form of ‘Ministry involvement’. These data could be used to support increased funding for AIDPs.
5. For all AIDP workers, particularly those who are not currently located within multiservice organizational hubs, to initiate or join a community early childhood

⁹⁴ As discussed in Chapter Two, this refers to the AIDP Provincial Advisor and the members of the Steering Committee.

network in order to support and strengthen intersectoral relationships and collaboration and improve families' access to a wide range of services and supports.

6. For all current and new AIDP workers to be offered ongoing professional support and development in the areas of: (a) family well-being and social determinants of health; (b) intra-organizational and intersectoral relationships; (c) cultural safety in the EI process; (d) trauma- and violence-informed early intervention, and (e) navigating the child welfare system.
7. For all AIDPs to have a strategy in place to engage more fathers and male caregivers in their programs.

7.4.2 Recommendations for the MCFD

The Director of Aboriginal policy at the MCFD has expressed an interest in the findings of this research. The following recommendations will be discussed with the AIDP leadership prior to the AIDP Provincial Advisor and myself discussing these with the Director of Aboriginal policy in MCFD:

1. For the MCFD in partnership with the Provincial Advisor of the AIDP to review workers' annual contracts so that expectations and deliverables are aligned with the distinct ways in which EI is conceptualized and provided.
2. For MCFD to support the Provincial Advisor in collecting data from individual AIDP workers by including this as part of the contract/program deliverables.
3. For the MCFD to actively address the current fragmentation of prenatal, maternal-infant health, health care, early childhood, child welfare, and social programs in BC. This may include the establishment of a delegated office that would advocate for policies and strategic collaborations among different levels and agencies of

government and Indigenous authorities to enhance the well-being of Indigenous families, women, and children living in off-reserve communities in BC. This office would co-ordinate its efforts with the Maternal-Child Health Committee of the FNHA.

4. For the Directors of Aboriginal and child welfare policies at the MCFD and the AIDP leadership to develop a strategic plan on how to address the increasing number of families and children being referred to AIDPs by child welfare social workers.
5. For MCFD to make the necessary financial investment in AIDPs so that all programs are sustainable and high quality while also meeting the demands of increasing referrals.
6. For the Director of Indigenous policy at the MCFD to collaborate with the AIDP leadership on the development of monthly statistical information that is aligned with how AIDP workers provide EI.
7. For the Director of child welfare policies at the MCFD to be informed of the need for a policy framework and targeted funding that enables social workers to provide support and prevention services for Indigenous families, including proactive policies and resources to support families who are struggling with chronic poverty.

7.4.3 Recommendations for Occupational Therapy Curricula in Canada

This research supports the recommendations made by the Truth and Reconciliation Commission (2015), in particular the importance of all health professionals understanding the historical and ongoing legacies of the residential school system in relation to Indigenous families and children's health and their experiences within the health care system. Recommendations, based on this research, for the

Association of Canadian Occupational Therapy University Programs include the need for all programs to:

1. Build relationships and collaborate with Elders and Indigenous university advisors⁹⁵ on how to provide occupational therapy students with knowledge on: (i) ways of honoring and representing Indigenous peoples in the curricula; (ii) Indigenous perspectives on health and well-being, and (iii) the history of colonization in Canada and its implications for Indigenous peoples' health and health care.
2. Integrate critical perspectives of social justice and health equity throughout the curricula drawing on examples of diverse populations groups within Canada who experience social marginalization and structural violence, including Indigenous peoples.
3. Develop curricula on: (i) cultural safety in routine occupational therapy practices; (ii) trauma- and violence-informed care, and (iii) occupational therapy practices that address determinants of health and foster health equity.

7.4.4 Recommendations for Early Intervention Therapy Programs in BC

The evidence from this research will be shared with the Provincial Advocate of the BC Association of Child Development and Intervention. This Association represents occupational therapists, speech language pathologists, and physiotherapists who provide EI. The recommendations include:

⁹⁵ For example, at UBC there is a Centre of Excellence in Indigenous Health.

1. For the ‘Early Intervention Therapy Program Guidelines’ (Ministry of Children & Family Development, 2009) to include evidence from this research on how to provide responsive EIT in the context of Indigenous communities, families, and children.
2. For management at child development and other organizations that host EIT programs to build relationships and alliances with urban organizations where Indigenous families are already accessing a range of programs and services.
3. For EI therapists to build relationships with, and provide their services and programs in, urban organizations where Indigenous families are accessing a range of programs and services. This needs to be a long-term commitment with therapists increasing their visibility, presence, and accessibility within these organizations and communities.

7.5 Future Research

As discussed in Chapter Two, intervention research on child health equity is currently lacking. The following recommendations for future research are made with this in mind.

1. Conduct longitudinal research to evaluate the impact of AIDPs on family well-being and children’s health equity. This would require the development of relevant outcome measures for the families and children who access AIDPs. Undertaking this research in collaboration with MCFD could also contribute to the development of a more meaningful system for this funding agency to collect data on AIDPs.
2. Conduct research on preventative forms of EI that support Indigenous families in raising their children and work towards reducing the number of children in state ‘care’.

3. Conduct research on how organizational and community structures and networks can be better integrated, in order to provide families with easier access to wide range of supports and resources that could include early intervention programs such as the AIDP. This could include research on the effectiveness of organizations that have embraced ‘a one stop shop approach’ to serving families and children, such as some Indigenous Friendship Centres.
4. Conduct research on how EIT, including occupational therapy, can be responsive to the strengths and needs of Indigenous families who are raising children with developmental challenges in conditions of social disadvantage.
5. Conduct research on how equity-oriented primary health care for adult populations who experience marginalization and structural violence can be provided in ways that also address the health and well-being of their children, and foster child health equity.

7.6 Concluding Comments

The critical theoretical framing of this dissertation research, as it was grounded in a relational epistemology, informed by postcolonial feminist and Indigenous feminist theoretical perspectives, and a decolonizing methodology, generates nuanced and contextualized understandings of how Indigenous families and children’s health and well-being are shaped by multifaceted structural inequities. This inquiry illustrates how AIDP workers’ experiences of being in relation with Indigenous families, communities, and organizations in different urban contexts across BC has had a profound impact on how their programs have innovated and transformed since their inception in 1992. This transformation was necessary in order for AIDP workers to engage families in their programs, and for their intervention to be respectful of, and responsive to, the historical,

cultural, socio-economic, and geographical contexts of families and communities' lived realities. This study provides evidence of how AIDPs play a vital role in the current and future health and well-being of Indigenous families and children. How AIDP workers provide EI may be perceived as being more complex and demanding than conventional child-focused forms of intervention. In addition, this study provides an analysis of the complexities and contradictions inherent in AIDPs' increasing affiliation with the child welfare system.

These findings are salient for other programs and professionals working with Indigenous families and children. From an occupational therapy perspective, they extend our understanding of how to provide occupational therapy in ways that are respectful and responsive for Indigenous families and children, and for all families who experience social marginalization and structural violence. From an occupational science perspective, this study illustrates the importance of drawing on critical theoretical perspectives in order to advance our understanding of the complexities of occupational engagement in the context of Indigenous families.

Employing a health equity lens in this study draws attention to how AIDP workers are implicitly enacting justice and equity through the EI process. This research is significant because it begins to address a gap in the current literature on *how* EI, as part of a network of community social supports, can play an important role in fostering health equity for Indigenous children. Moreover, this research fills a recognized gap in the international literature on intervention to foster child health equity (Bell et al., 2013; World Health Organization, 2013a).

Perhaps of most significance, this critical inquiry raises the question of whether health equity for children can be achieved without political will and action to address broader structural changes that advance an agenda of social justice and health equity for Indigenous communities, families, and women. This study supports the call for political action to address Indigenous children's health inequities that are unfair, avoidable, and remediable.

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Appendices

Appendix A: A Timeline of Key Events in the History of AIDPs in BC

Date	Event
Mid-1970s	A dialogue between leaders and Elders in five neighboring First Nation Bands on Vancouver Island lead to training, including teachings from Elders, for five Indigenous women from each Band.
1980-1983	Cowichan Tribes on Vancouver Island receives ‘sunset funding’ to provide a ‘Native Infant Program’.
1992	Nuu Chah Nulth Tribal Council and Cowichan Tribes launch two AIDPs with funding through the Tripartite Health Transfer Agreements.
1996	AIDPs expand to 11 communities. A working group comes together to determine the need for a provincial coordinator. A community survey is undertaken of all AIDPs.
2002	An AIDP provincial office is established. The BC Aboriginal Child Care Society is the host agency.
2003	AIDPs expand to 25 communities.
2005	Launch of an ‘AIDP Policy and Procedure Manual’.
2006	Five AIDP Regional Advisors are implemented to support AIDP workers in all health regions of BC. The AIDP provincial office relocates to the BC Association of Aboriginal Friendship Centers.
2007	A community survey is undertaken with all AIDPs.
2011	Receive an Award of Excellence from the Office of the Representative of Children and Youth in BC.
2012	AIDPs expand to 49 communities.
2014	A community survey is undertaken with all AIDPs.
2015	A qualitative research study is completed by Alison Gerlach.

Appendix B: AIDP Vision and Mission Statements

Mission Statement

Every child is a unique gift from the Creator. The Mission of the Aboriginal Infant Development Programs is to honor this gift by supporting the development of Aboriginal children within the context of the family, community, and culture, and by offering access to culturally appropriate early intervention and prevention support programs.

Vision Statement

All Aboriginal children born in British Columbia will be born healthy and free from preventable disabilities or delays. We envision our children being raised in loving and safe homes, within healthy, supportive, caring communities who practice cultural, meaningful values and beliefs. We also envision healthy and strong communities where the necessity of intervention programs is reduced and everyone is treated like a gift from our Creator.

Source: Elliott, D. (2012). Aboriginal Infant Development Program: Celebrating 20 years! The growth and development of an Aboriginal ECD program. Paper presented at the Early Years Conference, Vancouver, Canada.

Appendix C: Signed Memorandum with Community Research Partner



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Pathways to Health Equity for Aboriginal Children: A Critical Inquiry of an Aboriginal Early Child Development Program

Principal Investigator & Doctoral Supervisor: Dr. Annette Browne, Associate Professor, School of Nursing, The University of British Columbia. Phone: ~~604-822-7558~~

Co-Investigator & Doctoral Student: Alison Gerlach, Doctoral Candidate, Graduate Program in Rehabilitation Sciences, Department of Occupational Science and Occupational Therapy, The University of British Columbia. Phone: ~~778-938-6142~~

Dissertation Supervisory Committee: Dr. Margo Greenwood, Associate Professor, Department of First Nations Studies, The University of Northern British Columbia. Phone: 250-960-5239;
Dr. Melinda Suto, Assistant Professor, Department of Occupational Science and Occupational Therapy, The University of British Columbia. Phone: ~~604-822-7395~~

MEMORANDUM OF UNDERSTANDING: PROVINCIAL OFFICE OF THE ABORIGINAL INFANT DEVELOPMENT PROGRAM OF BRITISH COLUMBIA

This research will be designed and undertaken by Alison Gerlach, an occupational therapist-researcher, in collaboration with the Provincial Office and Steering Committee of the Aboriginal Infant Development Program (AIDP) of British Columbia. The research is part of Alison's doctoral studies in the Graduate Program of Rehabilitation Sciences degree at UBC, and will be overseen by her dissertation committee. The research is funded in part by a scholarship from the Canadian Institute of Health Research (CIHR). A summary of the research proposal is attached to this memorandum.

The research process will be respectful of the Royal Commission on Aboriginal Peoples Ethical Guidelines for Research; the principles of ownership, control, access, and possession (OCAP); guidelines published by the CIHR for health research with Aboriginal peoples, and the 'Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans' (TCPS-2).

By signing this memorandum of understanding, **The Provincial Office of the Aboriginal Infant Development Program of BC** formally agrees to collaborate with Alison Gerlach on this project as a community research partner. This research will involve Alison Gerlach recruiting and interviewing AIDP regional advisors and workers from different regions of BC (n=6-10); Aboriginal primary caregivers who have received or are currently receiving AIDP (n=12-15); Elders with knowledge of AIDP through their involvement with the AIDP Steering Committee or in a local advisory capacity (n=2), and administrative leaders of organizations that host AIDP (n=3). Interviews will be semi-structured, last from 45-60 minutes and with the participant's permission, will be audio-recorded. The interviews will be conducted as far as possible in person, otherwise by phone. The focus of the interviews will focus on discussing participants' perspectives on and experiences of AIDP. Participants can review their transcribed interviews and may be invited to participate



in a follow-up interview and/or a discussion to further explore, clarify and extend a preliminary analysis. Alison will also shadow a sample of AIDP workers in routine activities including home visits in order to observe how they interact with and support caregivers and children. Alison will also observe the physical environment and milieu of the common areas of organization that host AIDPs.

Participation in this study is completely voluntary, and participants can refuse to answer questions or to withdrawal at any time without giving any reason. To protect participants' rights to privacy and confidentiality, the Provincial Office of the AIDP will not know who decides to participate. Access to identifying information and data will be restricted to Alison, her doctoral supervisor and members of her dissertation committee (as listed above). All identifying information, including participants' names, location or the names of specific programs or organizations will be removed from the data. No identifying information will be used in any reports, publications or presentation. All research materials will be stored on password protected computer files and in locked filing cabinets in Dr. Browne's research office at UBC. This research will not proceed until it has been approved by the Research Ethics Board at UBC.

The findings of this research will be used to inform AIDP education, policies and practices and strengthen AIDP for Aboriginal families and children in BC. All research participants can choose to receive a final summary report and/or attend a community presentation and discussion of the research findings. A final summary report will also be provided to the Provincial Office of the AIDP and the Provincial Executive Director of the BC Association of Aboriginal Friendship Centres. Knowledge translation and exchange activities will be developed in collaboration with the Provincial Office of the AIDP and will be respectful and meaningful to a broad audience. The findings will also be published in Alison Gerlach's dissertation thesis and in a variety of publications and conference proceedings.

Signatures indicating a memorandum of understanding:

Signature:  Date: July 15th, 2013

Diana Elliott, AIDP Provincial Advisor
Provincial Office of the AIDP

Signature:  Date: July 18/13

Anita Zakresky, Chair of the AIDP Steering Committee
Provincial Office of the AIDP

Signature:  Date: July 23/13

Alison Gerlach, Doctoral Candidate

Appendix D: Information Brochure

<p>Who is doing the research?</p> <p>THIS RESEARCH IS A PARTNERSHIP BETWEEN:</p> <p>Alison Gerlach, Occupational Therapist-Researcher*</p> <p>&</p> <p>The Provincial Office of the Aboriginal Infant Development Program</p>  <p>*Alison's committee: Dr. Annette Browne, School of Nursing, UBC Dr. Margo Greenwood, Dept of First Nations Studies, UNBC Dr. Melinda Suto, Dept of OS & OT, UBC</p>	 <p>Interested? Any Questions?</p> <p>ABOUT THE PROJECT:</p> <p>Alison Gerlach Occupational Therapist- Researcher Phone/text: xxxxx Email: xxxxx or Dr. Annette Browne Alison's Supervisor Phone: xxxxx</p> <p>ABOUT THE RIGHTS OF A RESEARCH PARTICIPANT</p> <p>UBC Office of Research Services Phone: (toll free) xxxxx</p>	<p>We want to learn from you</p>  <p>INTRODUCING A RESEARCH PROJECT WITH THE ABORIGINAL INFANT DEVELOPMENT PROGRAM</p> 
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What is this project about?

Alison Gerlach is a registered occupational therapist who has been providing early intervention for Aboriginal families and children in BC for many years.

Alison is doing this research as part of a graduate university degree at UBC.

The goal is to learn more about the Aboriginal Infant Development Program of BC and how it promotes the health and wellbeing of families and young children.

To do this Alison is talking with:

- ❖ Aboriginal parents and caregivers who are receiving, or who have received, AIDP.
- ❖ AIDP regional advisors and workers.
- ❖ Elders with experience of AIDP.
- ❖ Administrative leaders of organizations that host AIDP.

Alison is also observing AIDP workers during their routine practices including on home visits.

Joining this study is completely voluntary – you do not have to be in this study.

- ❖ If you decide to volunteer – you can refuse to answer any questions and leave at any time - you do not have to give any reason.

If you decide to join the study, Alison would:

- ❖ Talk with you about your experiences with AIDP for 45-60 minutes at a time and place that is handy for you.

Findings from this study will be used to:

- ❖ Improve AIDP for Aboriginal families and children in BC.
- ❖ Inform AIDP education, practices and policies.

[Photograph used with permission of the Provincial Office of the AIDP]

How is your identity and privacy protected?

Your name **will not** be used in the study or in any reports written about the study.

Information that could identify you or anyone else **will not** be used.

AIDP **will not** have access to any of the information you provide.

Is there any payment for taking part in this study?

Aboriginal parents, caregivers and Elders will receive a small honorarium. A donation to the Provincial Office of the AIDP will be made in honour of all research participants at the end of the study.

This study will respect ethical guidelines for research involving Aboriginal peoples, including the principles of Ownership, Control, Access, and Possession (OCAP).

Appendix E: Verbal Script

By: AIDP worker

To: Aboriginal caregivers attending an AIDP-run group program and who are currently receiving AIDP

Hi everyone – I wanted to let you all know about a research project involving AIDP. There is a researcher called Alison who has worked with Aboriginal families and children in BC for many years as an occupational therapist. She is now at UBC and would like to interview parents and caregivers about their experiences with the AIDP.

Here is a brochure with some information about the study and it has Alison's email and phone/text number on it. You can either contact Alison directly from her contact information in this brochure or if you give me permission to pass along your contact information to Alison, she will contact you directly and will give you more information about the study. If you are interested and would like to meet Alison I could also invite her to come to one of our playgroups. It is completely voluntary and you do not have to take part.

Appendix F: Aboriginal Caregivers: Summary of Socio-demographic Information

Gender	Female n=9 Male n=1
Relationship to children receiving AIDP	Birth mother n = 9 Birth father n=1
Age	Average age: 36 ½ yrs (30-48 yrs)
Highest level of education	Less than grade 12 n=5 Grade 12 n=3 Post-secondary n=2
Marital status	Single n=7 Common law n=2 Divorced = 1
Number of children (any age)	Average: 3.5 (1-8 children)
Number of dependent children (under 18 yrs)	Average: 2.9 (1-8 children)
Number of dependent children cared for outside of family home	Average: 1.1 (1-4 children)
Living situation	Rented apartment n=8 Supported housing n=2
Employment status	Part-time employment n=3 Voluntary employment n=1 In school n=2 Not employed n=4
Length of time with AIDP	Average: 3.3 yrs (3 ½ mths-8 yrs)

Appendix G: AIDP Workers: Summary of Socio-Demographic Information

Gender	Female n=18
Age	Average = 45 yrs (30-58 yrs)
Self-identified ethno-cultural background	Aboriginal n=7 Caucasian n=11
Highest level of education	Diploma n=6 Bachelor degree n=9 Master's degree n = 3
Number of years of ECD experience	Average: 20 yrs (4-35 yrs)
Number of years with AIDP	Average: 7 ½ yrs (4-20 yrs)
Number of families on full-time caseload	Average: 18 families (15-28)

Appendix H: Interview Guides x 4

Interview Questions For AIDP Workers

1. Can you describe your program?

Prompts:

- What do you think is the value of AIDP?
- How has your program adapted to your particular location and the families and communities you serve?
- How does your program differ from other programs in your area serving families and young children? Can you give an example?
- How does your host organization/agency influence your program?
- How does your program connect with or tap into other programs or community resources?
- What are some of the challenges your program faces?

2. Can you tell me about the families and children who receive your program?

Prompts:

- Can you tell me about the challenges that some of your families face?
- Can you tell me about some of the ways your program responds to the diversity and complexity of families' lives?
- Do you think AIDP could do more to support families who face multiple challenges? Can you give an example?

3. Can you tell me about your experiences providing AIDP?

Prompts:

- How do you think the AIDP affects the health and wellbeing of families and young children? Can you give an example?
- What do you think is important for an AIDP worker to do when getting to know a family that has just been referred?
- How do you engage with a parent who may be reluctant to meet with you or access your program?
- How do you make a family or caregiver feel comfortable and safe with you?
- Can you think of a time when it went really well with a family – can you describe what happened?
- Can you think of a time when things did not go so well – can you describe what happened?

4. Are there any ways that you think your program could improve their services to families and young children?

Prompt:

- How would you like to see your program evolve over the next 5-10 years?
5. Is there anything else that you think I should know about?
- Prompt:
- Is there anything else you would like to comment or tell us about?

Interview Questions for Indigenous Caregivers

1. Can you tell me about your experiences with the Aboriginal Infant Development Program?
- Prompts:
- How does the AIDP support you and your family? Can you give an example?
 - What do you find has been most helpful? Can you give an example?
 - What do you find has been least helpful? Can you give an example?
 - How has the support from the AIDP affected your family and children's health and wellbeing? Can you give an example?
 - Was there ever a time when you did not feel that you received the support you needed from the AIDP? Can you tell me more about that?
2. Can you tell me about your AIDP worker and what it is like when she visits you at home?
- Prompts:
- Can you describe what it was like when you first met your AIDP worker?
 - What kinds of things does your AIDP worker help you with?
 - What do you rely on most from your AIDP worker? Can you give an example?
 - Can you give me an example of how your AIDP worker listens to you and makes you feel comfortable?
 - Can you think of any time when things didn't go well with your AIDP worker?
 - Has your AIDP worker helped you to access other services or programs for your family? What are they?
3. If you could give advice to a new AIDP worker working in your community what would you say?
4. If you could have whatever you needed for your family and children, what kinds of supports or services would help your family the most?
5. Is there anything else that you think I should know about?
- Prompt:
- Is there anything else you would like to comment or tell us about?

Interview Questions for Elders

1. Can you tell me about your involvement with Aboriginal Infant Development Program?
Prompts:
 - How did you become involved with the AIDP?
 - How many years have you been involved?
 - What has been your role with AIDP?
 - Do you think the AIDP could have more Elder involvement? Can you tell me more about that?
2. How do you think the AIDP supports families and young children?
Prompts:
 - How does the AIDP support families and children to be healthy and well? Can you give an example?
 - Do you think the AIDP could do more to support the families and children's health and wellbeing? Can you give an example?
 - How do you think the AIDP differs from other programs serving families and young children? Can you give an example?
 - Are there ways that the AIDP could do more to support families in raising healthy children?
3. AIDP workers visit a lot of families in their homes – what do you think about home visiting?
Prompts:
 - What do you think is important for an AIDP worker to do when getting to know a family that has just been referred?
 - What do you think is important for an AIDP worker to know or to do when visiting families in their homes?
 - What do you think an AIDP worker needs to do in order to make a family feel comfortable and safe during a home visit?
 - If you could give advice to a new AIDP worker, what would you say?
4. Is there anything else that you think I should know about?
Prompt:
 - Is there anything else you would like to comment or tell us about?

Interview Questions for Administrative Leaders

1. Prior to starting your current position – what did you know about Aboriginal children and their early health and wellbeing?
Prompts:
 - Did you know about the Aboriginal Infant Development Program prior to starting your current position?
2. Can you tell me about your experiences, as an administrative leader, with your AIDP?
Prompts:

- How are you involved as an administrative leader with the AIDP at your organization?
 - How does your organization support AIDP in their work? Can you give an example?
 - How does AIDP fit with other programs or services provided by your organization? And in your community?
 - How do you think your location effects AIDP?
 - How are your organizational values and policies aligned with those of AIDP?
 - Are there any challenges for your organization in supporting the work of AIDP?
3. How do you think AIDP supports families and young children?
- Prompts:
- How does AIDP meet the complex challenges that some families face?
 - How does the AIDP support families and children to be healthy and well? Can you give an example?
 - How do you think the AIDP differs from other programs serving families and young children? Can you give an example?
4. Are there any ways that you think your program could improve their services to families and young children?
- Prompts:
- Are there ways that the AIDP could do more to support families and young children?
 - How would you like to see the AIDP evolve over the next 5-10 years?
 - What role would you like to see your organization playing with AIDP in the future?
5. Is there anything else that you think I should know about?
- Prompt:
- Is there anything else you would like to comment or tell us about?

Appendix I : Visual Map - Initial Analytical Themes on Families' Everyday Lives

