

*Relational Pathways in Early Intervention:*  
**Research Summary Report**  
**for the**  
**Aboriginal Infant Development Program**  
**of British Columbia**



by  
**Alison Gerlach, MSc(OT), PhD(c)**

**Credits**

Principal Investigator/Report Author: Alison Gerlach: [Alison.gerlach@telus.net](mailto:Alison.gerlach@telus.net)

Community Research Partner: The Provincial Office of the AIDP of BC.

**Citation**

Gerlach, A. (2015). Relational pathways in early intervention: Research summary report for the Aboriginal Infant Development Program of British Columbia.

## ACKNOWLEDGEMENTS

This research was a partnership between myself, Alison Gerlach, as part of my doctoral studies in rehabilitation sciences at the University of British Columbia (UBC) and **the Provincial Office of the Aboriginal Infant Development Program (AIDP) of British Columbia (BC)**. In particular, I would like to thank Diana Elliott, the Provincial Advisor of the AIDP for her unwavering support, guidance, wisdom, and enthusiasm for this study. I would also like to extend my sincere appreciation to **all the participants involved in this study** who shared their time, perspectives, and lived experiences, and who trusted me with representing this knowledge through this research. It was a privilege to spend time together and I hope that I have done your ‘story’ justice. I would also like to thank my **doctoral committee** who have guided my transition from occupational therapist to researcher: Dr Annette Browne in the School of Nursing and Dr Melinda Suto in the Department of Occupational Science and Occupational Therapy at UBC, and Dr Margo Greenwood, Academic Leader of the National Collaborating Centre for Aboriginal Health and Professor in First Nations Studies and Education at the University of Northern British Columbia.

### About the Author

As a Euro-Canadian, educated professional I am very aware of my position of privilege within Canadian society and how my position in relation to Indigenous peoples is shaped by our colonial past and present. The motives, concerns, questions, and humility that I bring to this research flow from my experiences and relationships with Indigenous Elders, families, children, early childhood colleagues, and leaders as an occupational therapist and community researcher over the past 15 years (Gerlach, 2003, 2007; Gerlach & Gray Smith, 2009; Gerlach & Zeidler, 2004; Gray Smith & Gerlach, 2012b). In this study, I viewed myself as an advocate and ally *with* the Provincial Office of the AIDP 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.

## **Table of Contents**

<b>INTRODUCTION .....</b>	<b>5</b>
<b>Why Undertake this Research? .....</b>	<b>5</b>
<b>What was the Purpose of this Research? .....</b>	<b>7</b>
<b>ABORIGINAL INFANT DEVELOPMENTS PROGRAMS .....</b>	<b>8</b>
<b>Historical Timeline of AIDPs in BC .....</b>	<b>9</b>
<b>EARLY INTERVENTION ANCHORED IN RELATIONAL UNDERSTANDINGS OF FAMILY WELL-BEING .....</b>	<b>13</b>
<b>A Relational Process of Knowing.....</b>	<b>13</b>
<b>Relational Understandings of Family Well-Being.....</b>	<b>14</b>
<b>A RELATIONAL ORIENTATION TO EARLY INTERVENTION.....</b>	<b>16</b>
<b>REFRAMING THE EARLY INTERVENTION PROCESS .....</b>	<b>20</b>
<b>NAVIGATING SYSTEMS: HEALTH CARE.....</b>	<b>22</b>
<b>NAVIGATING SYSTEMS: CHILD WELFARE.....</b>	<b>23</b>
<b>THE BROADER EARLY CHILD DEVELOPMENT AND CHILD WELFARE LANDSCAPE IN BC .....</b>	<b>25</b>
<b>IMPLICATIONS OF THIS RESEARCH .....</b>	<b>28</b>
<b>(1) A Relational Orientation to Indigenous Early Childhood.....</b>	<b>28</b>
<b>(2) A Broader Scope of Early Intervention.....</b>	<b>28</b>
<b>(3) Trauma- &amp; Violence-Informed Approach.....</b>	<b>28</b>
<b>(4) Cultural Safety in Early Intervention .....</b>	<b>29</b>
<b>(4) Nestling AIDPs in Multi-Service Organizational Hubs .....</b>	<b>29</b>
<b>(5) A Complex Relationship: AIDPs and the Child Welfare System .....</b>	<b>30</b>
<b>TEN RECOMMENDATIONS ARISING FROM THIS STUDY .....</b>	<b>31</b>
<b>Concluding Comments .....</b>	<b>32</b>
<b>References.....</b>	<b>33</b>

## INTRODUCTION

*'Relational Pathways'* is a summary report of the findings and implications of a critical qualitative inquiry that was undertaken in partnership with the Provincial Office of the AIDP between 2013-2015. This report has been developed for AIDP workers and for their provincial funding agency, the Ministry of Children and Family Development (MCFD). However, the findings of this research are relevant to a wide range of programs and professionals who provide early child development and intervention for Indigenous<sup>1</sup> families and children in BC and beyond, and for all families who experience marginalization and oppression.

This research builds on the work of early childhood development (ECD) providers, 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).

### Why Undertake this Research?

There is increasing evidence that children who experience health inequities<sup>2</sup>, 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,

“The early childhood period is the most important developmental phase of life. Experiences during this time determine health, education and economic prospects throughout life” (World Health Organization, 2013, p. 28).

---

<sup>1</sup> 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” (Canadian Institute of Health Research, 2014, p. 2).

<sup>2</sup> Health inequities are ‘unfair, avoidable and remediable differences’ in the health status of individuals and population groups as a result of social and structural factors (World Health Organization, 2013).

Mattes, McMurray, & Stanley, 2009; Shonkoff, 2012). Many Indigenous children in Canada continue to experience a disproportionate level of social injustices and health inequities as a result of structural inequities<sup>3</sup> (Anaya, 2014; National Alliance for Children & Youth, 2011). Currently, there is a lack of research on *how* health inequities affecting Indigenous children are being, or could be, addressed in Canada and internationally. AIDPs appear to be ideally situated to play a vital role in influencing Indigenous families' well-being and fostering children's health equity. However, there is a lack of research on early intervention home-visitation programs serving Indigenous families and children and *how* these programs may further enhance their practices from a critical perspective of child health equity. This research was designed to address this gap.

#### **Indigenous Children's Health and Well-Being**

Despite some improvements in recent years, many Indigenous children remain significantly less healthy than other children in Canada on virtually all measures of health and quality of life (Findlay & Janz, 2012; Office of the Provincial Health Officer, 2009; Postl, Cook, & Moffatt, 2010; Smylie, 2012). Rather than being rooted in biomedical causes, the health and developmental outcomes of many Indigenous children stem from the social conditions into which they are born and spend the most important early years of their lives. Many of the challenges families face are frequently beyond their immediate control, as they largely stem from how our colonial society continues to sustain the economic and social oppression of many Indigenous communities and families (First Nations Information Governance Centre, 2012; Fontaine, 2007).

---

<sup>3</sup> When policies and practices, that are embedded in our social systems and organizations (such as health care, welfare, economic and justice systems), produce an unjust burden of social determinants for a particular population they are referred to as 'structural inequities' (Browne & Stout, 2012; Farmer, Nizeye, Stulac, & Keshavjee, 2007).

## What was the Purpose of this Research?

The purpose of this research was to generate knowledge on *how* an early intervention home-visiting program for Indigenous families and their children living in urban contexts in BC influences their health and well-being and is responsive to health inequities affecting children who live with social disadvantages that stem from structural factors. The perspectives and experiences of Indigenous caregivers of young children who accessed AIDPs, Elders involved with AIDPs, AIDP workers, and administrative leaders of urban organizations that hosted AIDPs were central to the production of knowledge and to answering the research questions.

### Questions Guiding this Research

- (1) How do AIDPs influence the health and well-being of Indigenous families and their infants and young children?
- (2) How do AIDPs foster child health equity?
  - 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?

## **ABORIGINAL INFANT DEVELOPMENTS PROGRAMS**

The AIDP of BC is a well-established early intervention home-visiting program for Indigenous families with young children from birth up 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 social and geographical contexts in which they live. Each AIDP is hosted and administered by a community-based organization, and is often co-located with other family and children services and programs. 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). AIDPs for families living in on reserve communities are funded federally, while programs for families living off reserve are funded provincially through the MCFD.

Since its inception in 1992, AIDP has grown from 2 to 49 programs. From 2012 to 2014, the annual number of children and families who have accessed AIDPs has been over 1,800 (Office of the Provincial Advisor for Aboriginal Infant Development Programs, 2013). Over the past 10 years AIDP have undertaken several province-wide surveys to gain community input and feedback on their programs. Feedback from communities has been overwhelmingly positive (Gray Smith & Gerlach, 2012a). In spite of garnering national and international attention, AIDPs currently exist only in BC.

While AIDPs and their mainstream counterpart, Infant Development Programs, may both be described as grassroots programs, their histories and orientation to early intervention reflect distinct worldviews. Since their early beginnings, AIDPs have had the freedom to evolve and adapt in order to engage families in their programs and be responsive to the contexts of families' lives (Office of the Provincial Advisor for Aboriginal Infant Development Programs, 2005). The AIDP leadership identified the need for research to more clearly describe and frame, from a theoretical perspective, how AIDPs influence families' and children's health and well-being, and how their programs can be further responsive to the unique strengths and needs of Indigenous families and children in different regions of the province.

## Historical Timeline of AIDPs in BC

<b>Mid-1970s</b>	Dialogue between leaders and Elders in five neighboring Bands on Vancouver Island led to training, including teachings from Elders, for five Indigenous women from each Band.
<b>1980-1983</b>	Cowichan Tribes on Vancouver Island receive ‘sunset funding’ to provide a ‘Native Infant Program’.
<b>1992</b>	Nuu Chah Nulth Tribal Council and Cowichan Tribes launch two AIDPs with funding through the Tripartite Health Transfer Agreements.
<b>1996</b>	AIDPs in 11 communities. Working group comes together to determine the need for provincial coordination. Initial community survey undertaken of all AIDPs.
<b>2002</b>	An AIDP Provincial Office is established with the BC Aboriginal Child Care Society as the host agency.
<b>2003</b>	AIDPs expand to 25 communities.
<b>2005</b>	Launch of an AIDP Policy and Procedure Manual.
<b>2006</b>	Five Regional Advisors implemented to support AIDP workers in all 5 MCFD health regions of BC. The AIDP Provincial Office relocates to the BC Association of Aboriginal Friendship Centres.
<b>2007</b>	Community survey undertaken of all AIDPs.
<b>2011</b>	Receive an Award of Excellence from office of Representative of Children and Youth in BC.
<b>2012</b>	AIDPs expand to 49 communities.
<b>2014</b>	Community survey undertaken of all AIDPs.
<b>2015</b>	Critical qualitative research study undertaken with Alison Gerlach.

## ‘RESEARCHING TOGETHER’

This study would not have been undertaken without the full support and participation of the AIDP Provincial Advisor and Provincial Steering Committee who acted as a ‘community research partner’. The research was developed in close collaboration with AIDP leadership through an ongoing dialogue that started 18 months before data collection commenced, and is ongoing as the findings are shared with different provincial, national, and international stakeholders.

This research was grounded in a relational worldview<sup>4</sup> (Thayer-Bacon, 2003; Wilson, 2008) and informed by two distinct but inter-related critical theoretical perspectives; postcolonial feminism (J. M. Anderson, 2002; Reimer Kirkham, Baumbusch, Schultz, & Anderson, 2007) and Indigenous feminism (K. Anderson, 2000; LaRocque, 2007). In taking up this theoretical framework, this study sought to generate a greater understanding of how: (a) past and present forms of colonization interplay with socio-economic and political structural inequities to shape Indigenous families’ and children’s everyday lives, opportunities, health and well-being and create child health inequities; (b) Indigenous caregivers’ (who were primarily mothers in this study) were supported in exerting their agency and resistance through the early intervention process, and (c) participants’ knowledge on children’s early health and well-being and early intervention challenged, and were distinct from, taken-for-granted normative assumptions about these concepts. Also, the knowledge generated by this study needed to have practical implications that could benefit Indigenous families and children.

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 (Dahlberg, Moss, & Pence, 2006; Woodhead, 2011).

---

<sup>4</sup> In a relational worldview, knowledge is “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). Relational worldviews are often at the core of many Indigenous knowledge systems (Wilson, 2008).

This study used a qualitative design and methods that were informed by, and aligned with the Canadian Institute of Health Research and 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, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council, 2014).

All of the AIDPs in this study were based in urban centres of varying sizes and locations in four distinct geographical regions of BC. Several of these programs 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.

**Research Participants N=35**

AIDP workers n=18

Caregivers\* n=10

Elders n=4

Admin Leaders n=3

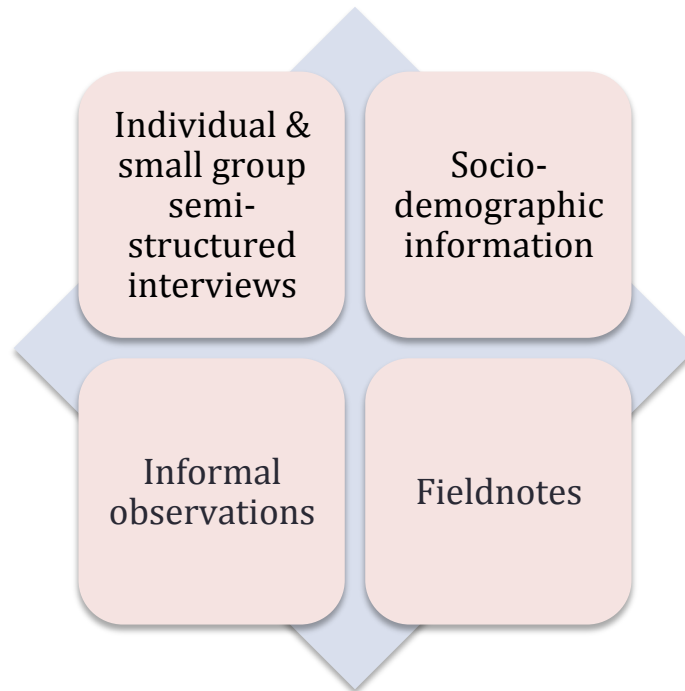
[\*Mothers n=9 and father n=1]

Individual and small group semi-structured interviews (in person or by phone) were undertaken in four different regions of the province with a total of 35 participants.

Following informed and signed consent, all interviews and focus groups were audio-recorded, transcribed and all identifying information was removed. Informal participant observation and field

notes were also kept. A limited amount of socio-demographic information about the two primary participants groups: AIDP workers and caregivers, was also collected to help contextualize the findings.

## Methods of Data Collection



Critical analysis of the findings was informed by the theoretical perspectives that informed this inquiry and took place over an 18 month period. The quality of this research was 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. The preliminary analysis and findings were shared and discussed at two community meetings with AIDP workers and regional advisors (some but not all of whom participated in this study), Elders and Aboriginal and non-Aboriginal early childhood program providers in two different regions of the province. This process was important in clarifying, extending and validating the findings.

## EARLY INTERVENTION ANCHORED IN RELATIONAL UNDERSTANDINGS OF FAMILY WELL-BEING

### A Relational Process of Knowing

AIDP workers reported how they learnt *from*, rather than about, communities and families through a deeply relational and personal process of inquiry. 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 various community

AIDP worker: *"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"*.

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. Workers' often intimate knowledge about families' stories and histories frequently developed over the course of several years. AIDP workers' knowledge was also shaped by their personal identities and lived experiences.

A central and recurring foundation for developing relationships with families was

Mother: *"It's safe for you to express what you need to express and ask for help.. because you know, they're not gonna 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.."*

workers' understanding that due to the historical and current high number of Indigenous children being apprehended by the child welfare system (Representative for Children and Youth, 2013), gaining caregivers' trust took a substantial amount of

time. Workers' were aware of their own values, assumptions and 'place of privilege' and repeatedly stressed the importance of being non-judgmental in their interactions and relationships with families.

## Relational Understandings of Family Well-Being

Workers' relational perspective of early childhood and intervention extended the focus beyond an individual child's health and development to include the health and

AIDP worker: *"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"*

AIDP worker: *"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?"*

Elder: *"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"*

well-being of the family as a whole. This broad and relational orientation to early intervention has evolved in response to workers' understanding the multiple ways in which the daily lives of many of the families who accessed their programs were influenced by social determinants. This approach was also necessary in order to engage families in their programs in ways that were respectful and meaningful.

The caregivers who participated in this study, and supported by the perspectives of the other participant groups, described how intersecting social determinants influenced their everyday lives. Many of the participants perceived the current over-surveillance and intervention of the child welfare system as a continuation of historical forms of state intervention, including residential schools and the 'Sixties scoop'. As a result, many of the families who accessed AIDPs were initially suspicious of workers who took an interest in their children and were guarded about accessing programs for their children, sharing information, or asking questions.

A recurring theme was the multiple ways in which families' lives and caregivers' agency were profoundly influenced by the downstream effects of poverty, particularly

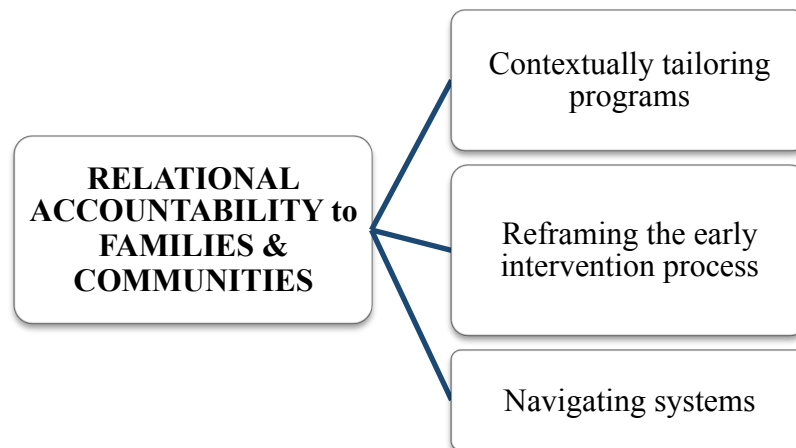
food and housing insecurity. A concerning finding was that families' experiences of food and housing insecurity was frequently described by participants as being perceived by the child welfare system as willful parental neglect.

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

AIDP worker: *"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".*

## A RELATIONAL ORIENTATION TO EARLY INTERVENTION

In thinking about how workers' enacted their relational understandings of family well-being in their routine practices, I have drawn on Cree writer/researcher Shawn Wilson's concept of 'relational accountability' (2008). Taking up and extending the concept of relational accountability to early intervention draws attention to how AIDP workers recognized that their in-depth knowledge of a family's and community's story and history must be used respectfully, responsibly, and in ways that directly benefited family and community well-being. Findings show that there were three predominant ways in which AIDPs enacted their relational accountability in the early intervention process, which are summarized in the following visual:



### Contextually Tailoring Programs

Workers described spending extensive amounts of time being in communities with the clear goal of building relationships in order to learn from community leaders, Elders, and other key stakeholders about how to tailor their programs for a particular community context. Tailoring AIDPs for particular community contexts signifies a distinct shift in power and expectations in program-community relationships. Contextually-tailoring programs

AIDP worker: *"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".*

Admin. Leader: *“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”.*

Elder: *“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”.*

Mother: *“When you walk in the door for the first time I think you feel the synergy in the building... and 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”.*

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).

Findings highlight how urban-based AIDPs, in different regional and organizational contexts, were tailored for women. 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. 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). These findings raise questions, however, about the gendered nature of AIDPs and the risk of failing to be responsive to the particular interests, strengths, and priorities of male caregivers.

AIDP workers routinely provided opportunities for women to come together in group programs with or without their children in attendance. There was agreement amongst the caregivers 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.

Many of the mothers in this study spoke passionately about the friendships and social supports they had developed in AIDP group programs. For many of the mothers in this study, the interpersonal relationships that evolved through AIDP groups provided a much-needed sense of belonging. Furthermore, 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 skills, and emotional support. Thus, group programming fostered women's knowledge, agency, and mutual support in raising their children.

Findings suggest that women's sense of belonging was also fostered over time by coming together in caring and supportive relational spaces with other Indigenous family members, Elders, and workers.

AIDP workers questioned how to respect and foster the diversity of Indigenous knowledges and identities in urban contexts. In working towards addressing these challenges, many workers had developed lasting relationships with one or more Elders.

Mother: “[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”.

Mother: “*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”.*

The 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 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

AIDP worker: *"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 ran 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.. . 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,*

imported parenting programs sometimes failed to do. There was also evidence that fostering Indigenous knowledges and sense of belonging was also strengthened when AIDPs were located within Aboriginal Friendship Centres.

## REFRAMING THE EARLY INTERVENTION PROCESS

Reframing the focus and pace of the early intervention process was necessary, so that workers could engage families in their programs and be responsive to families' lived realities in ways that contributed towards family well-being and fostered child health equity. Workers reported putting aside their taken-for-granted practices and embracing a flexible and dynamic approach to engage families in their programs and ensure that their program 'fit the family'. Workers discussed how engaging families in their programs,

*AIDP Worker: "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".*

routinely involved giving parents choices as to where to meet and their level of involvement in a program. Some parents chose to meet workers in a communal

setting such as a playgroup or daycare, or more personally in their homes, a local coffee shop, park, or whilst grocery shopping.

Workers also explained how they adapted the timing of their intervention to a

*AIDP worker: "With AIDP my sense and consistent I think with Indigenous 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".*

pace that was informed by their understandings of family well-being and 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.

Findings suggest that workers were particularly attuned to the timing of screening a child's development. Workers recognized that many parents perceived developmental screening as a "test, pass and fail and something to be worried about as opposed to helping build on strengths" (AIDP worker). Workers described the importance of delaying screening until a relationship with a family had been well established.

Mainstream early intervention tends to focus on an individual child's early health and development as the primary concern. A significant finding in this study is how early intervention was responsive to caregivers' concerns and priorities that often focused on family well-being. Families' lives were frequently constrained by the downstream effects of poverty. In response, workers discussed how they routinely supported families in accessing basic determinants, particularly food security. Additional ways in which workers were responsive to families' day-to-day lived realities included:

AIDP worker: *"Sometimes just even being able to just find milk for their infants and just even thinking about healthy food choices and those kinds of things. But just even running out, you know, when they had income coming in they'd be fine but and when they'd come to the program certain times of the month would be a real struggle and so sometimes the focus would be just making sure that they have access to be able to get food to be able to bring home because they'd be very emotional and couldn't do anything until that was provided".*

helping with housing applications; providing transportation to medical appointments; teaching caregivers how to budget for and prepare healthy affordable meals; and, as discussed below, navigating the health care and child welfare systems.

AIDP worker: *"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"*

There was also evidence of how workers' capacity to be responsive to families' strengths and needs was influenced by their host organization. Urban AIDPs are typically administered by, and nestled within, large community-based organizations. Workers described how their intra-organizational relationships increased families' access to a wide range of typically siloed adult and children's resources, services, and programs that they may not have otherwise known about or have accessed.

## NAVIGATING SYSTEMS: HEALTH CARE

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 their job’. 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 as a result of having previous negative and at times distressing experiences.

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. Workers described how their presence during health care visits provided women with much needed emotional support and disrupted overt expressions of racism by health care providers.

*AIDP worker: “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”.*

*AIDP worker: “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”.*

## NAVIGATING SYSTEMS: CHILD WELFARE

In response to the increasing number of families with ‘ministry 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.

Mother: *“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”.*

In navigating this system with families, workers sought to reduce the trauma of unclear and inconsistent state-mandated requirements that determined whether caregivers

AIDP worker: *“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”.*

would retain, or regain, their rights to raise, or be involved in raising, their children.

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’ as a result of their interactions with the child welfare system.

AIDP worker: *“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. And this woman has horrific circumstances and has no family, and so I talked to her about what does the ministry want, what were their expectations?”.*

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.

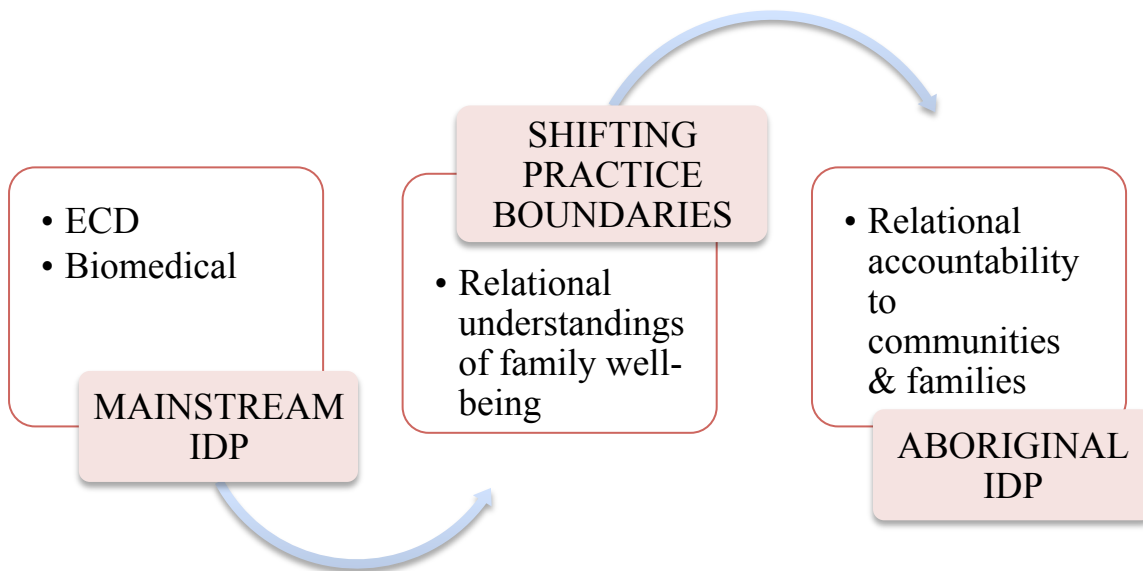
Mother: *"I think that's why AIDP is so important because if . . . you give the mom some encouragement and support her in other realms of her life. It's like you don't have to live like this. You have skills, you are important, you are a good mom, you know, not coming from a place from judgment"*.

AIDP workers' knowledge on maternal-infant attachment 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. 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 excerpt (opposite), however, highlights the vital role a worker played when she was informed and able to be present for children as they were being removed from their biological parents

AIDP worker: *"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 say to them, you know, and stay with them at the home with the foster parents who just met them and the social worker left"*.

## THE BROADER EARLY CHILD DEVELOPMENT AND CHILD WELFARE LANDSCAPE IN BC

A significant and recurring theme in the findings is that AIDP workers' relational accountability and pragmatic approach to early intervention frequently disrupted their previous more formalized learning about ECD and early intervention, as summarized in the following visual:



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 early intervention programs or, as referred to by many of the AIDP 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. As one worker stated: "If I'm on my agenda it just doesn't work well". Workers discussed how more

AIDP worker: *"But for me to even talk about a child's speech delay when they don't 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".*

child-focused forms of intervention were deferred until the timing was right for each family.

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’, and practice in ways that were often distinct from their prior ECD education and experiences. Findings indicate that some AIDP workers frequently felt overwhelmed as they were ‘called on to be many things for families’ and were ‘always working in the grey zone’. 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. In working in the grey zone within the broader ECD landscape, workers described feeling ‘judged and undervalued’ by ‘mainstream therapists or other professionals’.

AIDP worker: *“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”.*

AIDP worker: *“[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”.*

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”, as described by one worker, of prevailing ECD knowledge and practices. This was particularly evident in how workers were expected to use standardized tools to screen and report on children’s development.

Findings indicate that the voluntary nature of AIDPs was being increasingly curbed as 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. Workers' expressed their concerns about

AIDP worker: *"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".*

AIDP worker: *"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".*

'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 deter families from engaging in their programs. 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 early intervention or 'prevention' for families who are not 'ministry involved'.

## **IMPLICATIONS OF THIS RESEARCH**

### **(1) A Relational Orientation to Indigenous Early Childhood**

Indigenous children's early life experiences and health trajectories are often shaped by the intersecting and cumulative effects of historical and current forms of state intervention, poverty, and systemic racism that affect their families' lives and material circumstances. A relational orientation emphasizes family well-being as a foundational determinant of health and highlights the inseparability between the social contexts of families' lives and their children's current and future health, well-being, and life opportunities (Greenwood & de Leeuw, 2012; Reading & Wien, 2013). This relational orientation is consistent with Indigenous perspectives on health and well-being (Hovey et al., 2014; Kirmayer et al., 2009).

### **(2) A Broader Scope of Early Intervention**

Rather than a one-size-fits-all approach, this research illustrates how engaging communities and families in early intervention 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 intervention required workers to bridge typically siloed institutional and disciplinary boundaries that included maternal-infant health, child welfare, and family support services.

AIDPs workers have built on and extended their mainstream roots, as their relational understandings of family well-being expanded the scope of their intervention. Moreover, the socially-rooted nature of health inequities affecting Indigenous children required workers to implicitly reframe their intervention to be broad, multifaceted, and socially responsive.

### **(3) Trauma- & Violence-Informed Approach**

This study highlights how AIDP 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, poverty and systematic dismissal and discrimination in their encounters with mainstream institutions.

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' draws attention to how caregivers' 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).

#### **(4) Cultural Safety in Early Intervention**

This research fills a gap in the evidence-based literature on cultural safety in the context of early childhood programs for Indigenous families and children. The ways in which workers' recognize families' experiences and the socio-historical contexts of their lives as valid and essential forms of knowledge to inform the early intervention process, and how workers routinely adapted the pace and nature of their intervention to promote a more equitable distribution of power, are consistent with the key principles of cultural safety (Gerlach, 2007, 2012; Ramsden, 1993, 2005). Workers' strengths-based approach, in which they seek to support caregivers' positive identity and agency in raising their children, is also consistent with culturally safe early intervention.

#### **(4) Nestling AIDPs in Multi-Service Organizational Hubs**

This study extends our understanding of how AIDP workers relationships within multi-service organizational hubs, 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). Workers' relationships within these organizations increased families' and children's access and use of a wide range of programs that they may otherwise not have accessed.

## **(5) A Complex Relationship: AIDPs and the Child Welfare System**

While the families that are mandated to participate in AIDPs may benefit from early intervention, central values of these programs, such as their voluntary nature and support of caregivers' agency, are devalued and threatened by the growing relationship between AIDPs and the child welfare system. Workers' caseloads are not only increasingly full of families referred by the child welfare social workers, but their closer affiliation with 'the ministry' risks that families' will be 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.

## TEN RECOMMENDATIONS ARISING FROM THIS STUDY

- 1) For the AIDP Provincial Office and Steering Committee to draw on this evidence to explicitly name and frame the distinct ways in which AIDPs provide early intervention.
- 2) Following the lead of one program, for AIDPs to be renamed: ‘Aboriginal Family and Infant Development Programs’, or an alternative that reflects programs’ distinct orientation to family well-being and broad scope of early intervention.
- 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 develop a strategic plan on how to address the increasing number of families and children being referred to AIDPs by child welfare social workers. This could include collecting statistics from every AIDP worker on the number of families on their caseloads that have: (a) been mandated to attend by a child welfare social worker; or (b) have some form of ‘ministry involvement’. These statistics could be used to inform a dialogue with MCFD and 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 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 new AIDP workers to be offered professional support and development in:
  - (a) Family well-being and social determinants of health.
  - (b) Intra-organizational and intersectoral relationships.
  - (c) Trauma- and violence-informed approach.
  - (c) Cultural safety in the early intervention process.
  - (d) 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.
- 8) For MCFD to make a greater financial investment in AIDPs so that all programs are sustainable and high quality while also meeting the demands of increasing referrals.

- 9) For MCFD and the AIDP leadership to collaborate on the development of monthly statistical information that is aligned with how AIDP workers provide intervention.
- 10) For early intervention therapists (OTs, PTs, SLPs) to build relationships with, and provide their services and programs in urban organizations where Indigenous families are already 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.

### **Concluding Comments**

This research demonstrates how AIDP workers' experiences of being in relation with Indigenous families, communities, and organizations in different urban contexts across BC since their inception in 1992, has influenced how their programs have innovated and transformed beyond their mainstream roots. 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 families and communities' lives.

The findings of this research illustrate how AIDPs influenced families' health and well-being and worked towards fostering child health equity. Workers' relational accountability in the early intervention 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 was characterized by: contextually tailored programs for urban contexts, a critical reframing of the early intervention process, and advocacy and support for women and their children as they navigated the health and child welfare systems. In addition, the ways in which workers reduced 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' relational accountability to families has resulted in them having to navigate professional tensions and challenges in their relationships within the broader ECD landscape, their funding provincial agency, and the child welfare system. This research highlights early intervention with Indigenous families and children as a complex, nonlinear, and dynamic relational process that is infused with 'respect, reciprocity, and responsibility' (Wilson, 2008).

## References

- Anaya, J. (2014). Report of the special rapporteur on the rights of indigenous peoples, James Anaya, on the situation of indigenous peoples in Canada. Retrieved from [http://www.ohchr.org/Documents/Issues/IPeoples/SR/A.HRC.27.52.Add.2-MissionCanada\\_AUV.pdf](http://www.ohchr.org/Documents/Issues/IPeoples/SR/A.HRC.27.52.Add.2-MissionCanada_AUV.pdf)
- Anderson, J. M. (2002). Toward a post-colonial feminist methodology in nursing research: Exploring the convergence of post-colonial and black feminist scholarship. *Nurse Researcher*, 9(3), 7-27. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2002117216&site=ehost-live>
- Anderson, K. (2000). *A recognition of being: Reconstructing Native womanhood*. Toronto, Canada: Sumach Press.
- Assembly of First Nations. (2005). *Early childhood development single window strategy: Summary report of First Nations regional dialogue sessions*. Retrieved from Ottawa, Canada:
- Ball, J., & Pence, A. (2006). *Supporting Indigenous children's development*. Vancouver, Canada: UBC Press.
- Bell, R., Donkin, A., & Marmot, M. (2013). *Tackling structural and social issues to reduce inequities in children's outcomes in low- to middle-income countries, Office of Research Discussion Paper No.2013-02*. Retrieved from Florence, Italy:
- Blackstock, C., Bruyere, C., & Moreau, E. (2006). Many hands one dream: Principles for new perspectives on First Nations, Inuit and Metis children and youth. Retrieved from <http://www.fncaringsociety.com/sites/default/files/manyhands-principles.pdf>
- British Columbia Aboriginal Child Care Society. (2011). *Handbook of best practices in Aboriginal early childhood programs*. Retrieved from Vancouver, Canada:
- British Columbia Assembly of First Nations, First Nations Summit, & Union of BC Indian Chiefs. (2008). Indigenous child at the centre action plan. Retrieved from [http://fnbc.info/sites/default/files/resource-files/ICATC\\_60189\\_Action\\_Plan\\_\(f\).pdf](http://fnbc.info/sites/default/files/resource-files/ICATC_60189_Action_Plan_(f).pdf)
- Browne, A. J., & Stout, M. D. (2012). Moving towards nahi: Addressing health equity in research involving Indigenous people. *Canadian Journal of Nursing Research*, 44(2), 7-10. Retrieved from <http://www.ingentaconnect.com/content/mcgill/cjnr/2012/00000044/00000002/art00002>
- Browne, A. J., Varcoe, C., Smye, V., Littlejohn, D., Godwin, O., Krause, M., . . . Lennox, S. (2012). Closing the health equity gap: Evidence-based strategies for primary health care organizations. *International Journal for Equity in Health*, 11(59). doi:10.1186/1475-9276
- Canadian Institute of Health Research. (2014). Institute of Aboriginal peoples' health newsletter: January 2014. Retrieved from <http://www.cihr-irsc.gc.ca/e/48181.html>
- Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council. (2014). Tri-Council policy statement: Ethical conduct for research involving humans. Retrieved from [http://www.pre.ethics.gc.ca/pdf/eng/tcps2-2014/TCPS\\_2\\_FINAL\\_Web.pdf](http://www.pre.ethics.gc.ca/pdf/eng/tcps2-2014/TCPS_2_FINAL_Web.pdf)

- Dahlberg, G., Moss, P., & Pence, A. (2006). *Beyond quality in early childhood education and care: Postmodern perspectives* (2nd ed.). London, United Kingdom: Falmer.
- Farmer, P. E., Nizeye, B., Stulac, S., & Keshavjee, S. (2007). Structural violence and clinical medicine. *PLoS Medicine*, 3(10), 1686-1691.  
doi:10.1371/journal.pmed.0030449
- Findlay, L., & Janz, T. (2012). Health of First Nations children living off reserve and Metis children younger than age six. *Health Reports, Statistics Canada*. Retrieved from <http://www.statcan.gc.ca/pub/82-003-x/2012001/article/11624-eng.htm>
- First Nations Early Childhood Development Council. (2011). The BC First Nations early childhood development framework. Retrieved from <http://fnecdc.ca/wp-content/uploads/Framework-Final-Nov20113.pdf>
- First Nations Information Governance Centre. (2012). *First Nations regional health survey (RHS): Phase 2 (2008/10) National report for adults, youth and children living in First Nations communities*. Retrieved from Ottawa, Canada:
- Fontaine, P. (2007). Protecting our gifts and securing our future: Eliminating poverty among First Nations children. *Pediatric Child Health*, 12(8), 653-655.
- Gerlach, A. J. (2003). *Cultural issues and Canadian First Nations families: Implications for collaboration*. (Master of Science), San Jose State University, San Jose, CA.
- Gerlach, A. J. (2007). *Steps in the right direction: Connecting and collaboration in early intervention in collaboration with Aboriginal families and communities in British Columbia*. Retrieved from Vancouver, Canada:
- Gerlach, A. J. (2012). A critical reflection on the concept of cultural safety. *Canadian Journal of Occupational Therapy*, 79, 151-158. doi:10.2182/cjot.2012.79.3.4
- Gerlach, A. J., & Gray Smith, M. (2009). *Community engagement: Aboriginal early years strategic planning*. Retrieved from Victoria, Canada:
- Gerlach, A. J., & Zeidler, D. (2004). *A guide for culturally-focused early intervention therapy programs for Aboriginal children and families in British Columbia*. Retrieved from Vancouver, Canada:
- Gray Smith, M., & Gerlach, A. J. (2012a). *Evaluation report: Aboriginal infant development programs of British Columbia*. Retrieved from Victoria, Canada:
- Gray Smith, M., & Gerlach, A. J. (2012b). *'Warmed by the fire': A narrative story of the First Nations urban Aboriginal early childhood reinvestment initiative*. Retrieved from Victoria, Canada:
- Greenwood, M. (2005). Children as citizens of First Nations: Linking indigenous health to early childhood development. *Pediatric Child Health*, 10(9), 553-555.
- Greenwood, M. (2006). Children are a gift to us: Aboriginal-specific early childhood programs and services in Canada. *Canadian Journal of Native Education*, 29(1), 12-28.
- Hertzman, C., Li, J., Mattes, E., McMurray, A., & Stanley, F. (2009). Social determinants of child health and well-being. *Health Sociology Review*, 18(1), 3-11.
- LaRocque, E. (2007). Métis and feminist: Ethical reflections on feminism, human rights and decolonization. In J. Green (Ed.), *Making space for Indigenous feminism* (pp. 53-71). Black Point, Canada: Fernwood.
- National Alliance for Children & Youth. (2011). *7 Key issues affecting children and youth in Canada*. Retrieved from Ottawa, Canada:

- Office of the Provincial Advisor for Aboriginal Infant Development Programs. (2005). *Aboriginal Infant Development Program of British Columbia: Policy and procedures manual*. Retrieved from Victoria, Canada:
- Office of the Provincial Advisor for Aboriginal Infant Development Programs. (2013). *Annual report 2012-2013*. Retrieved from Victoria, Canada:
- Office of the Provincial Health Officer. (2009). *Pathways to health and healing: 2nd Report on the health and wellbeing of Aboriginal peoples in British Columbia. Provincial Health Officer's Annual Report 2007*. Retrieved from Victoria, Canada:
- Postl, B., Cook, C., & Moffatt, M. (2010). Aboriginal child health and the social determinants: Why are these children so disadvantaged? *Healthcare Quarterly*, 14, 42-51.
- Reimer Kirkham, S., Baumbusch, J. L., Schultz, A. S. H., & Anderson, J. M. (2007). Knowledge development and evidence-based practice: Insights and opportunities from a postcolonial feminist perspective for transformative nursing practice. *Advances in Nursing Science*, 30(1), 26. Retrieved from <http://ubc.summon.serialssolutions.com/link/0/eLvHCXMwQywwRy4PjAiXB5bAqkgXfLEKYtEOUIHvJsoQ4uYa4uyhC70kQLfAwsgEmD-AdRqwkjVJtUhONk-zNE62NEmzSAFVa0bmSZaWpslpaeYGScapJoaWSWnGhompFinAVoyloYVFIrC2SzPk2-9gt8nR3nvP5k1c3mtvHnkFAHtNN60>
- Representative for Children and Youth. (2013). When talk trumped service: A decade of lost opportunity for Aboriginal children and youth in B.C. Retrieved from [http://www.rcybc.ca/sites/default/files/documents/pdf/reports\\_publications/when\\_talk\\_trumped\\_service.pdf](http://www.rcybc.ca/sites/default/files/documents/pdf/reports_publications/when_talk_trumped_service.pdf)
- Shonkoff, J. P. (2012). Leveraging the biology of adversity to address the roots of disparities in health and development. *Proceedings of the National Academy of Sciences*, 109(2), 17302-17307. doi:10.1073/pnas.1121259109
- Smylie, J. (2012). *Our babies, our future: Aboriginal birth outcomes in British Columbia*. Retrieved from Prince George, Canada:
- Thayer-Bacon, B. J. (2003). *Relational "(e)pistemologies"*. New York, NY: Peter Lang.
- Varcoe, C., Browne, A. J., & Cender, L. M. (2014). Promoting social justice and equity by practicing nursing to address structural inequities and structural violence. In P. N. Kagan, M. Smith, & P. L. Chinn (Eds.), *Philosophies and practices of emancipatory nursing: Social justice as praxis* (pp. 266-284). Florence, KY: Taylor and Francis.
- Wilson, S. (2008). *Research is ceremony: Indigenous research methods*. Halifax, Canada: Fernwood.
- Woodhead, M. (2011). Child development and the development of childhood. In J. Qvortrup, W. A. Corsaro, & M. S. Honig (Eds.), *The Palgrave handbook of childhood studies* (pp. 46-61). London, United Kingdom: Palgrave MacMillan.