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ORIGINAL RESEARCH

Aboriginal women's experiences of accessing health care when state apprehension of children is being threatened

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Abstract

Aims. To report findings from a study examining the impact of the threat of child removal on Aboriginal women's experiences accessing of healthcare services.

Background. A wealth of data highlights the higher proportion of Aboriginal children in government care in Canada compared with non-Aboriginal children. Aboriginal women experience poorer health outcomes than non-Aboriginal women and face significant barriers to healthcare access. However, little is known about how these phenomena may intersect.

Design. The study was conducted in two phases: (1) a secondary analysis of interviews with Aboriginal women and healthcare providers ($n = 7$) that were collected for a larger study; and (2) primary interviews with Aboriginal women ($n = 9$) and healthcare providers ($n = 8$), conducted between July–October 2011.

Methods. Postcolonial feminist perspectives and the principles of exploratory, qualitative research guided this ethnographic study. Data were analysed using principles of thematic analysis and interpretive description.

Findings. Aboriginal women whose children are involved with the child protection system often experience complex sociopolitical and economic challenges, which intersect with the threat of apprehension. Such threat did not impact women's decisions to seek healthcare services for their children, but experiences of racism, prejudice and discrimination in mainstream healthcare agencies and the fear of child apprehension influenced their decisions to access health care for themselves in ways that deterred access.

Conclusion. Racism, judgment and discrimination towards Aboriginal mothers in healthcare agencies must be addressed. Educating healthcare providers about culturally safe approaches to care is critical to mitigating the ongoing impact of colonialism and its effects on health of Aboriginal people.

Keywords: aboriginal women, cultural safety, ethnography, nursing, postcolonial, racism, state apprehension

Why is this research or review needed?

- In recent years, Aboriginal peoples' health has improved considerably; however, the health of Aboriginal women and children remains significantly below that of non-Aboriginal women and children in Canada.
- In Canada, there continues to be an alarmingly high percentage of Aboriginal children living in government care.
- Little is known in the literature as to how the threat or fear of child apprehension has an impact on Aboriginal women's experiences of accessing healthcare services.

What are the key findings?

- Aboriginal women whose children are involved in the child protection system often experience complex sociopolitical and economic life challenges, which have an impact on their health and their opportunities to parent.
- The threat of child apprehension did not deter the majority of the women participants' from accessing healthcare services for their children.
- Racism, prejudice and discrimination in mainstream healthcare agencies, as well as the fear of child apprehension, had an impact on the women participants' decisions to seek healthcare services for themselves.

How should the findings be used to influence policy/practice/research/education?

- Nurse educators must ensure that nurses receive education that is critical in its understanding of culture; including education about culturally safe care and indigenous cultural training.
- The government must recognize the effects of poverty on the health of Aboriginal people and create policies that address the inequities in relation to the social determinants of health.

Introduction

In recent years, the health of Aboriginal people has improved significantly; however, the health status of Aboriginal women and children continues to fall significantly below that of non-Aboriginal women and children (Bourassa *et al.* 2004, Canadian Institute for Health Information 2004, Adelson 2005, Canadian Institutes for Health Research 2008, Browne *et al.* 2009a, Reading & Wien 2009, Veenstra 2009). Throughout this paper, Aboriginal people refers to the Indigenous people of Canada, including First Nations, Métis and Inuit people (Royal Commission on Aboriginal Peoples 1996). Health and access to healthcare services for Aboriginal women are known to be problematic and shaped by racism, discrimination and stereotypical thinking (Native Women's Association of Canada's 2002, Bourassa *et al.* 2004, Browne 2007). In particular, Aboriginal women are often late to access prenatal care, or avoid prenatal care entirely and often receive inadequate prenatal care (Heaman *et al.* 2005, 2007, Smith *et al.* 2005, Varcoe *et al.* 2013). However, in relation to Aboriginal people, health cannot be discussed without considering how sociopolitical and economic factors – largely stemming from a history of colonialism and ongoing oppressive government policies – have had an impact on many Aboriginal people (Bourassa *et al.* 2004, Kubik *et al.* 2009, Richmond & Ross 2009, Brown *et al.* 2012). For many Aboriginal families, these same factors have an impact on child rearing.

Background

In Canada, Aboriginal children continue to represent an alarmingly high percentage of the children in government care (Farris-Manning & Zandstra 2003, Trocmé *et al.* 2004, Browne *et al.* 2009a). Statistics from 2000–2002 estimated that 76,000 Canadian children were living in government care (Trocmé *et al.* 2004); 30–40% were of Aboriginal ethnicity (Farris-Manning & Zandstra 2003). In British Columbia, Aboriginal children comprise 54% of children in government care, despite representing approximately 8% of children in the province (British Columbia Provincial Health Officer 2009).

The disproportionately higher number of Aboriginal children in government care has been linked to Canada's history of oppressive government policies that continue to disrupt Aboriginal families and communities (Blackstock *et al.* 2004, Trocmé *et al.* 2004, Fluke *et al.* 2010, Bombay *et al.* 2011). Such disruption included the creation of the Residential school system where children were removed from their homes and placed into Residential schools (Furniss 1999, MacDonald 2002, Ing 2006). Aboriginal parents and communities were deprived of their children; children were robbed of their native languages and cultures (Ing 2006). The closure of the last Residential school in BC in 1984 (De Leeuw 2007) did not mark the end of government interruption into Aboriginal families and communities.

In 1951, provincial social workers were given the authority to enter Aboriginal people's homes and remove children from parents who did not meet white middle class parenting standards (Fournier & Crey 1997). 'Social workers deprived of the information, skills and resources to address the poverty, disempowerment, multi-generational grief and loss of parenting knowledge defaulted to a practice of mass removal…' (Blackstock *et al.* 2004 p. 903). The term 'sixties scoop,' refers to this mass removal of Aboriginal children that occurred from 1960–1980 (Sinclair 2007). Today, there remains distressingly high numbers of Aboriginal children in government care.

At the same time, research shows that many Aboriginal women face multiple barriers to accessing health care. In particular, our previous research has linked Aboriginal women's disproportionately lower levels of access to prenatal care to racism and discrimination (Calam *et al.* 2008, Brown *et al.* 2011, Varcoe *et al.* 2013). In a study of primary health care by urban Aboriginal healthcare organizations, we recognized that the dynamics of child protection were influencing women's healthcare access (Browne *et al.* 2011, 2012, Wong *et al.* 2011) and undertook the study reported in this paper to examine how the fear or threat of child apprehension has an impact on Aboriginal women's experiences accessing healthcare services.

Theoretical Perspective

Postcolonial feminist perspectives informed the study. Postcolonial theories are multidisciplinary perspectives, influenced by critical perspectives such as postmodernism, poststructuralism, feminism and neomarxism (Anderson 2002 Anderson 2004, Reimer-Kirkham & Anderson 2002 Reimer-Kirkham *et al.* 2007). Emerging in the 1960s–1970s, postcolonial perspectives are critical forms of inquiry that focus on the 'social, political and moral concern' around the historical and ongoing impact of colonialism (Browne *et al.* 2005 p.19). Postcolonial theories are particularly useful in nursing scholarship as they provide a strong framework and discourse for understanding how health and healthcare access are shaped by social, political and historical events (Browne *et al.* 2005).

Postcolonial feminist theory joins feminist theory to postcolonial inquiry in a manner that potentiates the explanatory powers of both perspectives (Browne *et al.* 2007). Including a gender analyses highlights the different experiences of women and men and emphasizes the unique, contextual experiences of the individual (Anderson 2002). For these reasons, postcolonial feminist theory is valuable in understanding Aboriginal women's health as it deepens understandings of racialization, historical subjugation, culture and class as social conditions that interact with gender to shape life opportunities and health.

The study

Aims

The study was guided by the following research questions: (1) What are Aboriginal women's experiences of accessing healthcare services when child apprehension is a threat? (2) What are the perspectives of healthcare providers with extensive experience working with Aboriginal women who: (i) have experienced child apprehension; or (ii) have had child apprehension threatened? (3) How can the quality of healthcare delivery to Aboriginal women and children be improved when child apprehension is a threat?

Design

The study used exploratory qualitative methods, following the general principles of ethnographic research. Ethnographic methodology examines human experiences including beliefs, relationship patterns and ways of living (Thorne 2000). The study was conducted in two phases and connected to a larger study of primary healthcare service delivery to Aboriginal and non-Aboriginal people at two urban Aboriginal health centres. Phase 1 involved a secondary analysis of previously collected in-depth interview transcripts and accompanying fieldnotes. Phase 2 involved collecting primary data in the form of in-depth, face-to-face interviews and associated fieldnotes.

Participants

Phase 1

Seven previously collected in-depth interview transcripts were selected from the larger study, using the following criteria: (a) Aboriginal women who spoke about experiences with child protection services ($n = 3$); (b) healthcare providers who discussed experiences of working with women involved in the child protection system ($n = 4$).

Phase 2

Participants were recruited using word of mouth, personal contact and snowball sampling through two sites: 'Site A' is located in the northern region of a Western Canadian province and is committed to providing services that are accessible and culturally safe to 'marginalized' people. 'Site B' is a programme located in an urban area that provides comprehensive services to pregnant and parenting women that have a current or past issue with drugs or alcohol.

The Phase 2 sample consisted of (a) Aboriginal women who had experienced the removal of their child or children by child protection services ($n = 9$, Table 1); and (b) healthcare providers with extensive experience working with women who have had child protection service involvement ($n = 8$, Table 2). The inclusion criteria were: emancipated women (referring to women who are free from the control of a guardian and thus are able to sign their own consent), over the age of 14 who self-identified as Aboriginal and

Table 1 Sociodemographics for women participants (phase 2).

Sociodemographic characteristics	Women participants (n = 9)
Self-Identified Ethnicity	Status First Nations n = 7 non-Status First Nations n = 1 Métis n = 1
Age range of women Participants	23–49 years of age (mean = 34)
Housing/Living Situation	Apartment/duplex n = 6 Shelter n = 2 Supportive housing n = 1

Table 2 Sociodemographics for healthcare provider participants (phase 2).

Sociodemographic characteristics	Healthcare provider participants (Site A n = 4 and Site B n = 4)
Self-Identified Ethnicity	Status First Nations n = 3 Caucasian or Euro-Canadian n = 4 Japanese n = 1
Occupation	Registered Nurse n = 2 Social Worker n = 1 Drug and Alcohol Counsellor n = 2 Physician n = 1 Peer Support Worker n = 1 Aboriginal Outreach Worker n = 1
Age range of Healthcare Provider Participants	34–63 years of age (mean = 48.6)
Years worked in Health care	5–27 years (mean = 17.4)
Years worked at current place of employment	1–17 years (mean = 6.2)

had experienced the threat of apprehension of their children by child protection services and healthcare providers with extensive experience working with such women.

Data collection

In Phase 1, over 40 in-depth interview transcripts from the larger study's data set were read; based on the inclusion criteria, seven in-depth interview transcripts and accompanying fieldnotes were chosen for analysis. In Phase 2, data collection occurred over a four-month period beginning in July 2011. Face-to-face, in-depth interviews lasting 30–90 minutes were conducted. The interviews were semi-structured, with some prepared questions. Fieldnotes were taken with each interview and used to record the process of the interview, including the tone of participants' voices, their body postures and their facial expressions. This provided important contextual data, which informed the analysis.

Ethical considerations

Ethics approval was obtained from the investigators' university and the regional health authority where Site B was located. Confidentiality and anonymity of participants were maintained at all times. Informed consent was obtained prior to conducting all of the interviews, which included a request to audio-record the interview. Due to the sensitivity of the topic, serious consideration was taken to ensure the safety and well-being of participants.

Data analysis

Data analysis began in the early stages of data collection and followed the principles of thematic analysis based on the procedures of interpretive description (Thorne 2008). The purpose of analysis is to recognize a significant moment, encode that moment and interpret what is being observed. In both Phases, each interview transcript was read multiple times. Initial coding was conducted independently by team members and then compared. After reading each interview transcript from Phase 1, broad coding categories were identified and coding began. Initial coding categories were refined as more data were collected, discussed and considered in light of the chosen theoretical perspectives and developed into themes. NVivo qualitative data analysis software (version 8) was used to organize and code the data sets. The same process was used for Phase 2; after categorizing data into broad codes, analysis continued and new linkages developed; sub-codes were identified, refined and re-organized throughout.

Rigour

Triangulation of interview data and fieldnotes collected from Aboriginal women at two different urban healthcare settings and interview data from healthcare providers contributed to the rigour and trustworthiness of the analysis (Thorne 2008). To validate credibility of the analytical insights, the researchers discussed the themes with experienced healthcare providers working directly with socially and economically marginalized Aboriginal mothers; they concurred that the themes in the data reflected the realities of women's lives (Mays & Pope 1995). To ensure accuracy of the methods, an audit trail of analytical insights and decisions was also maintained in the form of descriptive fieldnotes (Emerson *et al.* 2011).

The findings from Phase 1 were used to guide data collection in Phase 2, including designing recruitment and questions for interviews. Table 3 summarizes the insights from Phase 1

Table 3 Summary of phase one findings and related interview questions.

Theme	Findings	Interview questions
Socioeconomic Challenges Influencing Pregnant and Parenting Women's lives	The women participants' lives were all impacted by social, political and economic factors including poverty, substance use, violence and abuse, and other forms of trauma.	HCP- Can you tell me about the pregnant and parenting population that you serve? Where are they from? What proportion identify as Aboriginal? What are their lives generally like? HCP- Do you see many Aboriginal women accessing services at your centre pre or postnatally? Has that changed over years? Women- Can you tell me a bit about your family situation? Can you tell me a bit about your family now?
Fathers and Partners	Participants identified a gap in services for men or partners who were trying to parent and were also dealing with similar socioeconomic and political challenges such as violence, anger and substance use.	HCP- How could we better serve partners (men) dealing with issues such as anger and violence? HCP- Are there models of care or healthcare services that could incorporate male partners and still maintain the safety of the male's partner and/or children?
The fear of child apprehension and its impact on accessing healthcare services.	Women dealing with complex life circumstances found it extremely difficult to create the conditions that would be considered stable and healthy enough to maintain the guardianship of their child/children by child protection workers standards.	HCP- What services are available for pregnant or parenting women with living with substance use issues? Are there services available for pregnant and parenting women when they feel like they are going to need 'relapse?' (i.e. to use drugs or alcohol.) HCP- What can mothers do when they are 'in crisis' that would keep their children safe without losing custody of their children? HCP- How do you think the delivery of health care to pregnant or parenting Aboriginal women involved with child protection services could be improved? Women- How was it for you to get the healthcare services you needed during pregnancy? Women- I know you have had experiences with the child protection system and I am wondering if you can tell me about that? Women- Has the threat or fear of having your child(ren) removed ever affected your child to (i) whether you go for healthcare services (ii) where you go for healthcare services?
Benefits of Drug and Alcohol Counsellors	All of the women participants identified the drug and alcohol counsellors that they worked with at (where) to be key to maintaining or improving their health and well-being.	Women- How beneficial (or not) have you found drug and alcohol counselling?

and illustrates how the findings informed Phase 2. Analysis in Phase 2 further explored the findings from Phase 1.

Findings

The level of child protection service involvement varied with each woman participant; however, all had child protection service involvement at the time of interview. The findings indicate that Aboriginal women whose children are involved with the child protection system often experience complex sociopolitical and economic challenges, which shape the possibilities for their parenting and the way the women are perceived in social services. The child protection system and the healthcare system intersected in complex ways and

therefore the findings shed light on the participants' experiences with the child protection system. [In British Columbia, the Ministry of Child and Family Development (MCFD), often referred to as 'the Ministry,' is responsible for child protection].

Sociopolitical and historical context of women's lives

All of the women participants were dealing with numerous socioeconomic and political challenges. The healthcare providers described common life circumstances that were having an impact on women under investigation by child protection services as including: being lone parent or having an unreliable partner; having a history of being in foster care themselves; a lack of family or community support; living in poverty; being homeless or having inadequate housing; experiencing violence and abuse; having a history of experiencing other forms of trauma, mental illness or cognitive impairments; having drug and alcohol issues; and having low education levels. The two most salient sub-themes were the ongoing government disruption of Aboriginal families and communities and the influence of structural inequities and the context of poverty.

Ongoing disruption of aboriginal families and communities

Throughout Canadian history, Aboriginal families and communities have been disrupted through oppressive government policies. Several healthcare provider participants explained that one outcome of this disruption is that many of their Aboriginal women clients investigated by child protection services today were in foster care themselves as children. As this participant explained:

…[A] lot of our clients, they have no access to extended family or limited access to extended family and so limited access to a role model. A lot of [the clients] have had previous involvement with the Ministry as children themselves… (HCP 8)

As several participants described, one consequence of the disruption of Aboriginal families is that many women lack adequate support for raising children. One woman described what her social worker told her she needed to do to regain custody of her child, which included relocating to a shelter and leaving her partner:

I lived [in the shelter] for six months but I still wasn't…[I] didn't get the proper help to be a proper parent…I was still unsure of everything in this world. Then [the social worker] wanted me to leave the father and I was like, what? He's the only guy I know here in town, I don't have family, like what the hell are you guys trying do? (WP4)

The challenges of trying to raise a child with limited support most commonly appeared to result in two outcomes: women having to look after their children when they were not physically or mentally equipped to do so, or leaving children with someone who was not 'reliable.' Because many women involved with the child welfare system lived in poverty, having access to safe childcare was impossible.

Structural inequities and the context of poverty

The Aboriginal women participants were all living at, or far below, the poverty line. The healthcare providers stressed poverty as a leading factor for women likely to have child protection involvement. However, the context of poverty, as it relates to Aboriginal people, cannot be discussed without acknowledging how Canada's oppressive government policies have shaped the socioeconomic status of many Aboriginal people, as this participant described:

I realized that if I wanted to do something to prevent the apprehension of [Aboriginal] children… it is because of the colonial policy culminating in the Residential school experience… So people come through our doors, most of them don't know who they are, where they belong and poverty, poverty is held against them and it is straightforward, you can deduce that straight as a result of the colonial policies that Canada has held (HCP2)

Living in poverty has direct impact on one's health as well as one's ability to parent; the healthcare providers emphasized that when people are trying to obtain the essentials for survival, attending to health issues is not a priority. Attaining adequate housing was a central challenge associated with poverty. Inadequate housing is problematic because the parent's living situation needs to meet certain standards to be considered 'safe' for children by a child protection social worker (CPSW). Other poverty-related challenges included trouble getting transportation, adequate food and clothing. Poverty had a direct impact on the women's health and childrearing opportunities and intersected with the complexities of the child protection system to disempower the women.

The bureaucratic structures governing the child protection system

Participants relayed concern and frustration with the structure of the child protection services in British Columbia, emphasizing two main challenges: a lack of consistency from one CPSW to another and the power in the child protection system.

A lack of consistency

Both women and healthcare providers voiced concern with their experiences of CPSWs being unclear regarding what women are required to do to regain custody of their children. Several healthcare provider participants noted great variation from one CPSW to the next in terms of how custody decisions are made. One participant stated: '…[A]nd there's no consistency in what [each CPSW] does, like from worker to worker. Some workers will be okay, but others are so hard-lined…' (HCP 3) This lack of consistency created challenges for women as well as healthcare providers trying to advocate for women.

Power of the child welfare system

The consensus amongst all participants was that CPSWs possess substantially more power than mothers when it comes to child custody and visitation decisions. For example:

…God knows I don't think that the people who work [for the child protection system] are bad people because I don't. I just believe that they work for an institution that has a lot of power. And the colonial policies and the poverty, inter-generationally has affected the [Aboriginal people], so do things differently – meaning more support and less apprehensions. (HCP2)

From participant's perspectives, the power differential between the parent and the CPSW often caused women to feel powerless. Several women described being asked to complete a series of parenting programmes, but even complying with the CPSW's expectations did not always result in the return of their child, leaving women feeling defeated and at times resulting in 'backtracking' (e.g. using drugs or alcohol). Participants uniformly called for more supportive services to be available for families involved in the child protection system. In particular, affordable childcare and safe housing were seen as vital.

Aboriginal women's experiences with the child protection system

The participants generally agreed that once a woman became known to the child protection system, there was ongoing 'surveillance' of that woman. One woman described how she felt she needed to prove that she could parent the child she was carrying:

They were filling paper work to get him taken away when I was pregnant when I was like 24 weeks [pregnant], like when I spoke with my social worker, she was saying 'IF we don't take him away' like just letting me know she's going to take him away… it was so stressful when I was pregnant like all I did was worry about if they were going to take him away… (WP6)

This 'surveillance' of Aboriginal women in particular is quite problematic; many provider participants explained that some women go so far as to move to a different region to try 'to get off of 'the Ministry's' radar.' This is concerning because some women will move to remote regions that have limited healthcare services; rather than achieving the intention of improving well-being, access to health care is deterred.

Early referral process

Several healthcare providers described an option for women that are working towards parenting (i.e. trying to maintain custody of their child) but will likely have child protection involvement after giving birth, which was referred to as the 'early referral' to MCFD. This involved documenting the progress a woman may make throughout her pregnancy. The women are told that this is a voluntary option and healthcare providers saw this as helpful to preventing some unnecessary child apprehensions at birth:

…[What] we found in the early stages of this [programme] five, ten years into it, we had a relationship with clients but the Ministry had none. And so when the client would show up at the hospital and give birth we knew what was going on with the women but the Ministry only had their file. And so they saw all of their past history, so anything that the client had done to change during the time they'd been with us was never really noted… If we know [child protection services] are going to be involved we say [to the woman] due to your past history, why don't you just make the call [to the Ministry]…we will sit with you…and you can show them all the stuff that you have done to change…So trying to get the clients to work with The Ministry in a more proactive way…(HCP8)

The healthcare providers emphasized that suggesting that a woman call MCFD voluntarily requires significant trust in the healthcare provider–client relationship; relationship building is particularly crucial because women's previous experiences with mainstream healthcare services often have been negative.

Healthcare access in context

Understanding how the threat of child apprehension has an impact on Aboriginal women's access to health care is complex. The impact of the context of the women's lives – socioeconomic status, historical and ongoing colonial policies, violence, abuse, racism, discrimination, lack of

family/community supports, previous negative experiences with the healthcare system and previous experiences with the child protection system – appeared to intersect and shape individual women's decisions or experiences with accessing healthcare services. The threat of child apprehension operates as an additional factor that intersects with other sociopolitical and historical barriers that impact and shape access to health care and experiences in the healthcare system.

The majority of the women stated emphatically that if their child needed health care, they would not hesitate to take the child into a healthcare setting. However, both women and providers described how pervasive racism, discrimination and prejudice in mainstream healthcare agencies (i.e. hospitals) had an impact on both the women's healthcare experiences and their decisions to access services for themselves.

All participants provided examples of negative experiences in the healthcare system. These stories were primarily of racist or discriminatory nurses. In this next excerpt, the participant explained how harshly she was told to leave the hospital:

…[L]ike at [hospital name] I had pneumonia and I was really, really sick…and they discharged me I wasn't even better yet. My pneumonia hadn't even [gone away] and it was during wintertime. And…one of the nurses came in and said that the doctor is discharging you. I said I'm not even better yet and she said, well it's time for you to go now, you need to get your stuff and you need to go, don't let me call security. And sure enough she called security. Security literally came in, grabbed me behind my arms, dragged me down the hallways and threw me out the door, with pneumonia, in wintertime. And I went back in I said can I at least get a bus pass, a bus ticket? And they said this is not a charity this is a hospital. And right now I'm almost in tears… (WP9)

This was one of many stories women told of nurses being overtly racist and discriminatory. One nurse participant talked about the racism and discrimination she has seen in the healthcare system:

…[E]ven being in hospital is quite intimidating and even as a nurse, I worked for 13 years in labour/delivery and I worked in the [neonatal intensive care unit] and places like that as well. And even these places are not always the friendliest to our clients… And it's a sad thing to say but, quite often nurses … can be quite racist or judgmental… (HCP1)

Several of the women stated feeling as though the nurses did not want to 'deal' with the women because they were 'Native,' as this woman explained, '…[U]s Native women do get discriminated upon in the hospitals…Most of the time it's because the staff in the hospitals don't' want to deal with us, which I think is sad.' (WP8)

The women believed that they were discriminated against for being Aboriginal, appearing poor, for substance use, or for being teenage mothers. Consequently, racism, discrimination, judgment and the fear of child apprehension had an impact on the women's decisions and experiences with health care in two main ways: it deterred the women from visiting their children while in hospital and/or it deterred the women from seeking healthcare services for themselves. Healthcare provider participants explained that the fear of child apprehension for most 'marginalized' women who are trying to parent is always present; however, that fear may intensify when these women enter mainstream healthcare agencies because these settings are where the women particularly felt judged.

Discussion

This study aimed to explore how the threat of child apprehension had an impact on Aboriginal women's experiences accessing healthcare services. The sample of Aboriginal women inclusive of Phase 1 and phase 2 was not large (n = 11); however, the context of the women participants' lives was congruent with literature describing the socioeconomic and ethno-cultural characteristics of mothers involved in the child protection system (e.g. lone-parent households, low income and Aboriginal ethnicity) (Trocmé *et al.* 2001, Farris-Manning & Zandstra 2003, Blackstock *et al.* 2004).

The fear or threat of child apprehension had little impact on participants' decisions to seek healthcare services for their children. However, the fear of judgment by mainstream healthcare providers affected the quality of interactions at the individual level between the women and healthcare providers and the women's decisions to seek health care for their own health needs. This fear of judgment occurs in a context of economic and political disadvantage faced by many Aboriginal women (Bourassa *et al.* 2004, Canadian Institute for Health Information 2004, Adelson 2005, Canadian Institutes for Health Research 2008, Browne *et al.* 2009b, Reading & Wien 2009, Veenstra 2009). Thus, the influence of the threat of child apprehension on health cannot be discussed without taking into account factors that continue to impact Aboriginal people's health and well-being. In this section, we identify some key recommendations based on the findings.

Ongoing racism and discrimination in mainstream healthcare settings

One striking aspect of the findings was that all women participants described hospital nurses as conveying overtly racist and judgmental behaviours towards them. The women

participants described how previous negative experiences with nurses discouraged them from staying with their children on subsequent hospitalizations, which perpetuated further judgment. The well-documented racism, sexism and discrimination towards Aboriginal women through oppressive government policies (Ship & Norton 2001, Bourassa *et al.* 2004, Kubik *et al.* 2009, Castleden *et al.* 2010) can filter through and shape individual-level interactions. These findings are not unique; in a study examining Aboriginal women's experience with breast cancer, Poudrier and MacLean (2009) described 'invalidating encounters' such as racist remarks from healthcare providers towards Aboriginal women. Racism, discrimination and prejudice towards Aboriginal women and families in mainstream healthcare agencies must be acknowledged and addressed by policy makers, educators and leaders in the healthcare sector.

Assumptions about Aboriginal people have the potential to influence nurses' practice (Browne & Varcoe 2006, Browne *et al.* 2009b). Cultural safety, a concept developed in New Zealand by Maori nurse leaders in partnership with Maori people, may be useful in addressing the women's experiences of overtly racist attitudes and behaviours from healthcare providers. Cultural safety draws on the concepts of post-colonial theory to bring attention to how existing power imbalances shape people's health and access to healthcare services (Browne *et al.* 2005, 2009b).

Canadian nurses have been educated to understand culture primarily through a culturalist lens, which views certain characteristics of various ethno-cultural groups as 'cultural traits' without considering the complex sociopolitical and economic factors that shape people's lives (Smye & Browne 2002, Browne 2005, Browne & Varcoe 2006). For example, social constructions of Aboriginal mothers as 'neglectful' have been displayed in the media and other public forums, yet little attention is paid to wider sociopolitical and economic factors that lead to Aboriginal women experiencing higher rates of poverty and poorer health than non-Aboriginal women (Browne & Varcoe 2006). Therefore, a key recommendation is to ensure that healthcare providers receive education that is critical in its understanding of culture. Providing education about culturally safe care and indigenous cultural training to healthcare providers is essential.

The intersections of poverty, health and the child protection system

Poverty is a significant challenge impacting many Aboriginal women involved in the child protection system. The data emphasized a need for more social supports, as the available supports were not meeting the needs of the participants' communities. Pregnant and parenting women living in poverty need more assistance securing adequate food, shelter and income— the social determinants of health.

Aboriginal women are far more likely to live in poverty than other Canadian women (Pendakur & Pendakur 2011). Furthermore, one in every four First Nations children is growing up in poverty (Rothman 2007). There is a wealth of literature that links poverty to poorer health outcomes (Reutter *et al.* 2006, Canadian Institute for Health Information 2008). The government must recognize the effects of poverty on the health of Aboriginal women and children and create policies committed to addressing the inequities in relation to the social determinants of health. Lack of affordable housing is particularly problematic; it has impact not only on the health of individuals, but also on women's ability to provide for their children.

Addressing the legislative authority of the Child, Family and Community Services Act (CFCSA)

Most participants felt that CPSWs wield a significant amount of power, which was described as 'being held over [the women].' This power is CPSW's authority to enact the CFCSA (the CFCSA is the legislative authority for child protection services). A child protection social worker's legislative authority requires them to make custody decisions for a child. Although decisions are made in collaboration with supervisors, they appear to be largely judgment calls. Both Phase 2 findings and previously cited literature show that decisions about child custody partially are shaped by how the CPSWs interpret the CFCSA, which states child safety as paramount. Some CPSWs seem more comfortable making accommodations for less-than-ideal family circumstances (e.g. housing) and help families create safety plans; others seem less willing to make accommodations because the CPSW is ultimately responsible.

We recommend enhancing the supportive services available in child protection systems. Due to government cuts to social programmes, mothers are increasingly expected to gain the skills and resources necessary for parenting with little, if any, assistance (Brown 2006). This seems largely due to an underfunded child protection system, where the CPSWs have heavy caseloads and limited access to supportive services.

Limitations

Participants were primarily recruited from two agencies that provide comprehensive and relatively low-barrier services; therefore, these women's experiences of accessing healthcare services may not fully represent the experiences

of women who are not linked to similar programmes or services. Further research might capture the perspectives of Aboriginal women likely to be involved with the child protection system that are not connected to similar healthcare services.

Conclusion

The threat of child apprehension is yet another factor that shapes the health status and well-being of Aboriginal women and children. Many Aboriginal people continue to experience higher rates of poverty, social exclusion, discrimination and racism, which have an impact on all aspects of life (Blackstock & Trocmé 2005). Nurses need to encourage rather than deter access to quality healthcare services. To ensure quality care, nurses must be informed and aware of the ongoing impact of colonialism for many Aboriginal people, as well as trained to provide care that is culturally safe.

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Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (http://www.icmje.org/ethical_1author.html)]:

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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