MOTHERS, PROBLEMATIC SUBSTANCE USE, AND CHILD WELFARE IN NORTHERN BRITISH COLUMBIA

by

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THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF MASTER OF SOCIAL WORK

THE UNIVERSITY OF NORTHERN BRITISH COLUMBIA

April 2011

Your file Votre référence
ISBN: 978-0-494-75185-5
Our file Notre référence
ISBN: 978-0-494-75185-5

Abstract

This study examines the experiences of mothers with problematic substance use (PSU) involved with the Ministry for Children and Family Development child protection services (MCFD). The study takes place in two communities in northern British Columbia (BC). The smaller of the two communities is not named in order to protect the anonymity of the study participants. The larger community of Prince George, has a population of approximately seventy-thousand. The study focuses on the mothers' experiences of their involvement in the child welfare system in BC. Specifically, the aspects of the mothers' involvement related to identifying and accessing drug and alcohol treatment programs, or drug and alcohol counselling services (ADS) as mandated by MCFD. This qualitative, exploratory study provides a descriptive look at the women's experiences. The data is comprised of one on one, in-depth interviews conducted with ten mothers and one key worker, an experienced drug and alcohol counsellor. Demographic data were gathered using a questionnaire. The interviews took place between November 2008 and September 2009. A descriptive analysis of the data reveals a number of recurring themes. Participants identified the challenges encountered in their involvement with MCFD. The women also shared the personal impact of these problems. The mothers made recommendations for improving the experience of involvement with child welfare and ADS. The paucity of research specific to this population of women living in Northern British Columbia motivated this thesis.

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Acknowledgments

As with so many of life's accomplishments, this thesis is a product of the contributions of many people. My sincere gratitude for the patient support of my thesis supervisor, Dr. Glen Schmidt, whose dedication to teaching, improving the lives of marginalized people, and genuine kindness, inspire me to be a better person. My gratitude to Dr. Judy Hughes, whose commitment to giving voice to women brings me hope and the courage to continue fighting the good fight. Sincere thanks also to Dr. Catherine Nolin, whose dedication to social justice and academic excellence inspires me to set the bar higher.

I owe much gratitude to the courageous women who shared their own stories for this thesis. This work would not have been possible without them. I am also very grateful for the support of my fellow thesis group members. Thanks to each of you for your friendship and support through the inevitable pitfalls of thesis writing.

To my most amazing daughter, Holly, who, through her experience of having two parents in university simultaneously, has grown to believe that everyone has homework all the time. Thank you sweet pea for giving me time to do my homework.

Dedication

This thesis is dedicated to my mother, Mary Sanford, who has always been my most ardent and unwavering support through my entire, circuitous academic career.

Chapter One: Introduction

For more than a decade, I have worked in the human service field in various capacities. I have been a child protection social worker, provided family support services, counselled youth and their families in an alternate school, and worked with families whose members have disabilities. In each of these roles I have witnessed family members, often parents, struggling with problematic substance use, and the related harm that it rendered. The British Standing Conference on Drug Abuse (SCODA, 1997) developed the following definition of substance misuse: "in general misuse can be taken to mean the use of drugs which leads to harm (social, physical and psychological)" (SCODA, 1997 in Kroll and Taylor, 2003, p. 28). For the purpose of this thesis research, the term problematic substance use (PSU) describes drug use that negatively affects a person in the context of his/her life, and leads to harm. The harm is due to the drug use negatively affecting any of the following aspects of life: relationships, mental and/or physical health, an inability to maintain employment, interfering with parenting children, criminal involvement due to illicit drug use, or other behaviour that may be associated with drug or alcohol use (Salmon, Poole, Morrow, Greaves, Ingram, & Pederson, 2006). Unless otherwise specified, this term is used to include the use of illicit and prescription drugs, as well as alcohol.

As a former child protection worker I am affected most profoundly by the stories of mothers who struggle with problematic substance use while attempting to parent their children. My relationships with these mothers were frequently conflictual by virtue of the power and authority of my position. However, I felt and continue to feel deep empathy for these mothers and their children. The role of child protection social worker immerses

one deeply in the interactions of families, laying bare intimate details of what are often crises. My experience as a child protection social worker helped me to understand the complexities of trying to meet the needs of a diverse population of families within the context of a large bureaucratic system, whose workers must operate within the confines of sometimes limiting policies, procedures, and legislation. I am inspired by the dedication of my former colleagues in child protection work who are committed to the difficult but important role of helping families involved in the child welfare system.

Through this research, I hope to contribute to an improved societal and professional understanding of the realities of the experiences of mothers with problematic substance use. I hope that a better understanding will subsequently lead to more compassion, and improved services for them and their families so that they can be appropriately and adequately supported in parenting their children.

Theoretical perspective - Structural social work and feminist influence

Mauthner and Doucet (1998), feminist qualitative scholars, state that reflexivity is a fundamental theme in feminist research and they describe it as "making explicit where we are located in relation to our research respondents…[and] also acknowledging the critical role we play in creating, interpreting and theorizing research data" (p. 121). My experience working as a child protection social worker will invariably influence my perspective and perceptions; which can be useful, as Charmaz (2006) explains, "sensitizing concepts and disciplinary perspectives provide a place to start, not to end" (p. 17). On a personal level, my white, or Caucasian, privilege, blue collar upbringing, Canadian university education, extensive travels, experience as a woman, and as a member of a family affected by problematic substance use, have all influenced my interpretation of the stories of the women I interviewed. In an attempt to maintain some

degree of transparency, and awareness of this influence, I engaged in an ongoing reflexive process, keeping a journal and reflexive notes.

The theoretical influences on my practice and research are many, however, the two most apparent are structural social work and feminist social work theory. Structural social work theory emphasizes the need for analysis of oppressive social order and structures, viewing "traditional social work... as a form of social control that maintains social problems" (Heinonen & Spearman, 2006, p. 262). "It is widely accepted that the history of social work and its role in surveillance on behalf of a patriarchal welfare state means that women remain socially oppressed and social work does not do much to alter that" (Payne, 2005, p. 257). In my view, some child protection practices informed by policies and legislation in British Columbia (BC) fall under this category to some extent, and subsequently exacerbate the difficulties faced by women with PSU and their families. A discussion of three specific practice issues that fall into this category follows. The first is the risk assessment model used by the BC Ministry for Children and Family Development (MCFD) child protection social workers to determine the level and degree of risk to children. The next practice issue is the lack of training that social workers receive with respect to problematic substance use. The third practice issue is the lack of coordination in planning and service provision between child welfare and substance misuse treatment programs.

Patriarchy, the undervaluing of women's work and contributions to society, complacency to violence against women, racism, sexism, and homophobia, represent but a few oppressive societal structures (Mullaly, 1997). In patriarchal societies people are lead to believe that the 'others', those not belonging to the dominant societal group, are

different and therefore a threat. In order to limit the threat to patriarchal societies the dominant group oppresses the 'others' (Mullaly, 1997). Feminist therapist, Van Den Bergh, (1991) suggests that many of the 'others' who belong to oppressed groups in society attempt to cope with their sense of powerlessness through the consumption of drugs and alcohol, or behaviours such as gambling. Mullaly (1997) cautions that the societal context is paramount to the understanding of oppression, and how the "psychologizing of what are essentially social problems contributes to women's oppression... placing the blame for personal troubles squarely on the shoulders of women experiencing them" (p. 166). This contextual understanding of how oppression is embedded in the experiences of women with problematic substance use, has profoundly deepened my compassion for them.

Fundamental to feminist social work is the concept that the personal is political; that is to say that personal experience is "at the very root of social/political change" (Home, 1991 in Turner, 2002, p. 64). My understanding of social work practice and research is strongly influenced by this concept. Dominelli (2002a:7) "defines feminist social work practice that starts from an analysis of women's experience of the world and focuses on the links between women's position in society and their individual predicaments to create egalitarian client-worker relationships and address structural inequalities" (in Payne, 2005, p. 258). Two feminist social work principles that this research will attempt to fulfill include validating the subjective experience of the individual (Heinonen & Spearman, 2006), and giving women "space to voice their own needs and solutions (Dominelli, 2002a, in Payne, 2005, p. 259). Van den Bergh (1991) explains that women are socialized to believe in an external locus of control and thus

attribute their abilities and successes to chance, or a 'powerful other'. It is against this theoretical backdrop that I developed this thesis research.

Need for a gendered perspective

It is only over the past three decades that research and program development into the issue of problematic substance use for women has been initiated (Minister's Advisory Council on Women's Health, 2004). By 2001, there were more than 100 studies internationally, not including those in the U.S., that used gender-differentiated data to look at alcohol use, and related problems (Wilsnack & Wilsnack, 2002). The results of the longitudinal Gender Alcohol, and Culture, International Study (GENACIS), thus far indicate that both biological influences and culturally defined gender roles merit consideration in the development of prevention and treatment programs (Wilsnack & Wilsnack, 2002). Salmon, et al. (2006) present a cogent argument that significant gender differences are apparent in the causes, forms, and consequences of problematic substance use and these factors must be integral to policy and program development. They wisely caution that to fail to do so, and to continue implementing gender-neutral policies will essentially continue "to entrench inequalities for women and men experiencing symptoms of compromised mental health and/or problematic substance use and to construct barriers to effective and compassionate care" (p. 30). Indeed, partly due to a lack of a gendered lens on this problem to date, these barriers, which will be addressed in detail below, currently exist and negatively effect the ability of women with substance misuse problems to access treatment (Minister's Advisory Council on Women's Health, 2004; Poole & Gavin, 2003; Tait, 2000).

Gender-based analysis (GBA) is defined by Health Canada as "an analytical tool that systematically integrates a gender perspective into the development of policies,

programs and legislation, as well as planning and decision-making processes. It helps to identify and clarify the differences between women and men, boys and girls, and demonstrates how these differences affect health status, access to, and interaction with, the health care system" (Health Canada, 2008).

Estimates are that 10 to 20% of women who use substances in Canada (including alcohol, illicit and prescription drugs, and solvents), have substance misuse related problems such as illness, involvement with child welfare services, loss of productivity at work, and involvement in the justice system to name a few (Minister's Advisory Council on Women's Health, 2004). While literature specific to problematic substance use among women and girls from a Canadian perspective is available (Poole & Dell, 2005), a dearth of related literature specific to rural women (Aston, Comeau, & Ross, 2007; Booth & McLaughlin, 2000) and particularly so for women living in northern Canadian communities (Vaillancourt & Keith, 2007) is apparent.

Northern BC

Northern BC encompasses a vast geographic area, though some debate exists about what area constitutes Northern BC. For this research, Northern BC refers to both an urban centre, Prince George, commonly referred to as the Northern capital, a community with a population of approximately 70,000, and the many small towns and rural communities of Northern BC included in the map of BC (Appendix A).

Debate about what constitutes "rural" is ongoing, and understandable as some estimates consider 90% of Canada's land base to be rural (Pong, 2001, p. 108). One of Statistics Canada's definition of "rural and small town communities are those outside the commuting zone of larger urban centres" (du Plessis, Beshiri, Bollman, Clemenson, and Statistics Canada, 2001). The term rural is commonly used to describe most communities

outside of urban centres which is why "the term 'rural' is unlikely to disappear from everyday parlance or health service planning discourse because it is such a convenient label and is so ingrained in our consciousness" (Pong, 2001, p. 108). Some researchers argue that the important distinctions between urban and rural in Northern BC have more to do with the "underlying dimensions of rural life" (Booth & McLaughlin, 2000, p. 1269). Examples of these underlying dimensions include how community, or regionally based, economic disruptions that have a negative impact on local economies increase the likelihood of stress related illness and alcohol misuse (Bergland, 1988, in Booth & McLaughlin, 2000). An important underlying dimension of rural life in Northern BC communities, is the almost exclusive economic dependence on natural resources in the regional economy, which are often subject to boom or bust cycles (Bradbury, 1988). These cycles may correspond with increases in need for mental health and problematic substance use treatment services.

The problem and research objectives

The study examines mothers' experiences of trying to simultaneously: meet the requirements of MCFD, fulfill the expectations of the treatment program they attended, manage their problematic substance use, and attempt to regain, or maintain custody and care of their children under the age of 19. The research also asks the mothers to consider what, if anything, or anyone, within, or outside of these systems was helpful to them in managing their problematic substance use and parenting their children. My research question is: What is the experience of mothers with PSU when attempting to simultaneously meet the expectations of MCFD child protection services and treatment services for their problematic substance use?

The main objectives of this research are as follows:

- to provide mothers with problematic substance use and child welfare involvement the opportunity to relay their experiences of their MCFD involvement;
- to gain an understanding of the contextual realities of the lives of these mothers and their children who are living in Northern BC, as defined below, and consider any aspects of their experiences that are specific to Northern BC;
- to ask these mothers to make recommendations based on their experience of involvement with these systems;

Maternal problematic substance use, particularly among women of lower socio-economic status, increases the likelihood of child welfare involvement (Rittner & Davenport-Dozier, 2000; Semidei, Radel & Nolan, 2001; Trocmé et al., 2005). Increased likelihood of involvement is especially true for single mothers and Aboriginal women (Boyd, 1999; Blackstock, Trocmé, & Bennett, 2004). Awareness of the connection between parental problematic substance use and child abuse and neglect is found in literature (Grella, Hser, & Huang, 2006; Jones, 2004; Sun, 2000; Trocmé, Tourigny, McLaurin, & Fallon, 2003; Walsh, MacMillan, & Jamieson, 2003). A lack of social worker training in screening for problematic substance use and related problems interferes with thorough assessment of the family's functioning. Consequently, this lack of training also interferes with early and appropriate intervention (Dore, Doris, & Wright, 1995; Rittner & Davenport-Dozier, 2000).

Evidence suggests the need for coordinated service provision between child welfare and treatment services for problematic substance use (Azzi-Lessing & Olsen, 1996; Carlson, 2006; Humphreys, Regan, River, & Thiara, 2005; Semidei, Radel, Nolan, 2001). The lack of cooperation and coordination between these two systems interferes

with mothers receiving comprehensive treatment that adequately meets their needs (Azzi-Lessing & Olsen, 1996; Child Welfare League of America, 2001). Additionally, treatment of problematic substance use for mothers must address the underlying issues, and the barriers to their accessing treatment (Carlson, 2006; Salmon, Poole, Morrow, Greaves, Ingram, & Pederson, 2006). Effective design of treatment programs requires addressing the issues and barriers to treatment, and overcoming them. In rural and remote communities where treatment services exist, the services must be flexible in service provision to meet the varied and specific needs of a diversity of rural women (Aston, Comeau, & Ross, 2007).

Mothers with problematic substance use who are involved with the child welfare system are often mandated to attend treatment while their children are removed from their care and placed in foster homes, or with relatives (Gregoire & Delray, 2001). Competing demands contribute to many mothers struggling with problematic substance use for years. Often these mothers must simultaneously juggle: the need to function in the role of parent; meet the requirements of child protection services; overcome the barriers to accessing treatment, and do so with insufficient and inappropriate resources and support (Greaves, Varcoe, Poole, Morrow, Johnson, & Pederson, 2002; Marsh, D'Aunno, & Smith, 2000; Tait, 2000). Failure on the part of the mothers to manage these many demands can result in the loss of custody and care of their children to child welfare. For mothers to succeed in managing problematic substance use and parenting their children, coordination between child protection services and substance abuse treatment programs is imperative (Poole & Isaac, 2001).

Chapter Two: Literature review

Problematic substance use (PSU) is a complex social problem. A contextual examination of the lives of mothers with PSU can serve to provide a deeper understanding of some of the possible contributing factors, and the many difficulties faced in attempting to manage it. While this literature review will examine the contextual realities of mothers with PSU, there is recognition that although the context of their lives may contribute to the development of PSU, the context does not necessarily suggest causality for their PSU. That, in each of their stories, at some point, an element of personal responsibility exists in the choice to use drugs or alcohol, and some degree of responsibility for the subsequent harm that may, or may not, come from that use. The intent of this review is to look beyond the element of personal responsibility, which is often the predominant focus, to a broader view of maternal PSU (Salmon, Poole, Morrow, Greaves, Ingram, & Pederson, 2006).

Despite a growing awareness of the need to support people with PSU, social stigma remains, which is particularly true for mothers. Historical theoretical models that describe PSU are introduced, and related to social stigma and preconceived notions about PSU. The discourse embedded in societal notions of mothering, and the implications for women, are also considered. Some of the effects of maternal PSU on children and families are discussed in relation to the child welfare system. Some limitations of the child welfare system in British Columbia are considered, as is the need for more cooperative work between the child welfare and substance use treatment systems. Special consideration is given to issues pertinent to rural communities in northern British Columbia.

Social stigma

Social stigma against women with PSU is apparent, oppressive, and often internalized by these women (Finkelstein, 1994; Whiteside-Mansell, Crone, & Conners, 1999). The media plays an integral role in perpetuating negative stereotypes and perceptions of women with PSU, and in particular vilifies mothers; ignoring the context of their lives and failing to present the voices of these women (Greaves, Varcoe, Poole, Morrow, Johnson, Pederson et al., 2002). This vilification is particularly true for pregnant women, "public discourse regarding pregnant women who drink has been fundamentally judgemental, blaming, and unsympathetic" (Salmon, et al., 2006, p. 26). Stigma and discrimination are also experienced by women with PSU in their interactions with professionals in various capacities such as health care, social work, mental health agencies, and substance abuse treatment programs (Salmon, et al., 2006). Mitigating the women-blaming punitive stance that women with substance use problems encounter requires a feminist, structural social work perspective, using a gender-based analysis of practice, policies, and programs.

In terms of societal stigma, the issue of pregnant women who misuse substances is particularly contentious as evidenced by the 1989 Supreme Court of Canada trial of Ms. G. The Court overturned the lower court decision that ordered mandatory drug treatment for a young, pregnant, Aboriginal woman addicted to solvents (Rutman, et al., 2000). A punitive approach, or mandating women to hospitalization and/or treatment, can be extremely detrimental and counterproductive. In the U.S., a number of States, including South Carolina, have criminally prosecuted pregnant women who misuse substances (Dailard & Nash, 2000). The year after this South Carolina state court decision, the number of pregnant women attending addiction treatment programs in that

state dropped by 80%, and the infant mortality rate rose for the first time in seven years (Dailard & Nash, 2000). It is unlikely that the proponents of this legislation were hoping for this outcome. Legislating pregnant women to treatment further dichotomizes the rights of the fetus versus the rights of the mother. No simple answer will address this complex moral and ethical problem, but this example illustrates how well intentioned measures, implemented in the absence of careful examination of their implications, can potentially result in more harm. Programs that focus on support and care of pregnant women in reducing potential harm to themselves and their foeti have shown some success. In British Columbia, Sheway in Vancouver's downtown Eastside is one such program (Poole, 2000). The Sheway program opened in 1993 to address a number of prevalent issues in that community: the high incidence of infants exposed to alcohol and drugs in utero; a corresponding high incidence of low birth weights in infants and subsequent apprehension by MCFD; and increasing numbers of women with problematic substance use who received no prenatal care (Poole, 2000). The underlying philosophy is one of respect for, and support of, women's self-determination. The program takes a multi-disciplinary, woman-centred, harm reduction, culturally sensitive approach to proving service to at risk pregnant women (Poole, 2000). The program has successfully supported hundreds of women, improved health outcomes for infants born of high-risk pregnancies, and decreased the number of infants taken into MCFD care (Poole, 2006).

Models of addiction

Addiction models, theories, and treatment programs developed to explain and address substance misuse focused initially on serving the needs of men (Minister's Advisory Council on Women's Health, 2004; Nelson-Zlupko, Kauffman & Dore, 1995). These models are, therefore, inadequate in attempting to understand substance misuse in

women and for the needs of women with substance misuse problems (Poole & Gavin, 2003; Rhodes & Johnson, 1994; Salmon et al., 2006). However, these early models are useful in understanding how present day societal myths and beliefs about people with PSU emerged.

In reference to alcoholism in particular, two models informed early work in this area. The "moral model", originated in the 19th and 20th century temperance movement and associated alcoholism with moral failure. Since the model "endowed women with greater morality than men" (p. 146), it is particularly hard on women (Rhodes & Johnson, 1994). To some extent this model continues to inform contemporary public opinion about persons with substance misuse problems, and for women in particular this thinking contributes to the societal stigma they experience.

A physician, Elvin Morton Jellinek, developed the "medical model" or "disease model", in 1960 and identified alcoholism as a disease. While the disease model dismisses blame and attributes alcoholism to disease, it also tends to focus on pathology, particularly of the individual, making it of limited use in that it is too simplistic to incorporate the many complex contributing factors associated with substance misuse problems (Rhodes & Johnson, 1994).

The more contemporary "psychosocial model" includes environmental influences on the development of substance misuse, and considers there to be a continuum "from disease to wellness and, therefore, recognizes incremental growth" (Rhodes & Johnson, 1994, p. 151). This is the most comprehensive model of the three, and the only one that considers the etiology of substance misuse as external to the individual; for example

implementing interventions that address childhood, and adult abuse, violence, and the victimization of women.

A feminist perspective of women with PSU requires that one consider both the internal and external aspects of addictions for women (Van Den Bergh, 1991). Van Den Bergh purports that the internal aspects result from a 'fragile' sense of self often due to a trauma, or circumstance, which renders a person feeling hopeless and living in despair. Van Den Bergh looks at external influences in the form of societal inequalities such as poverty, marginalization, and segregation, as oppressive; both internal and external influences impose negative pressure. The person with the addiction uses substances, or behaviour, to assuage the resulting fear and anxiety, essentially self-medicating as a coping strategy. In describing what constitutes an addiction, Van Den Bergh states that it is "characterized by mental obsession as well as compulsive behaviour related to ingesting a substance (food, alcohol, drugs) or engaging in a process (gambling, sex, work)." (p. 6).

Underlying issues for women with PSU

In terms of the socio-economic context of the lives of women with PSU, research tells us that many of them face tremendous challenges. Most, but not all women with PSU, typically have experienced some form of trauma including emotional, physical, or sexual violence (Astley, Bailey, Talbot, & Clarren, 2000; Hien, Cohen, Miele, Litt, & Capstick, 2004; McHugo, Caspi, Kammerer, Mazelis, Jackson, Russell, et al., 2005; Morrissey, Jackson, Ellis, Amaro, Brown, & Najavits, 2005; Nelson-Zlupko, et al., 1995; Salasin, 2005; Wilsnack & Wilsnack, 2002). Many of these women are also seriously economically disadvantaged (Larson, Miller, Becker, Richardson, Kammerer, Thom, et al., 2005; Rutman, Callahan, Lundquist, Jackson, & Field, 2000). Many were

unemployed for at least a year prior to entering a treatment program (Sutker, 1981, in Nelson-Zlupko, et al., 1995), and are more likely than men to be financially dependent on social assistance, or a family member (Marsh & Simpson, 1986, in Nelson-Zlupko, 1995), or disability payments (Larson et al., 2005). PSU also affects the lives of a diverse population of women. Among this population are women with disabilities (Chappell, 2007; Larson, et al., 2005), older women (Flower & Cooper, 2007), lesbian, bisexual, and transgendered women (Doctor, 2007), homeless young women (Erickson, King & Ywit, 2007), women from diverse ethnocultural communities (Jategaonkar & Devries, 2007), and Aboriginal women (Varcoe & Dick, 2007). In addition to the multiple challenges faced by women with PSU in general, each of these populations of women also contend with internal and external challenges that are specific to their situations. Internal barriers can include "internalized social stigma, shame, isolation and anger" (Chappell, 2007, p. 84). External barriers can include a lack of program accessibility for women with restricted mobility, lack of sensitivity of service providers, and lack of gender specific options (Chappell, 2007).

There is a significant relational aspect to women's PSU. Women with substance misuse problems are more likely than men to reside with partners who themselves misuse substances, and/or discourage women from accessing treatment (Astley et al., 2000; Poole & Isaac, 2001; Sun, 2000). These women's family and friends are also likely to resist women attending treatment (Salmon, et al., 2006), and the women are often socially isolated (Poole & Isaac, 2001; Sun, 2000). Additionally, women who live in rural and remote communities may be more likely to be dependent upon a partner, or husband for financial support because "widespread patriarchal attitudes in many rural communities

reinforce traditional gender roles" (Health Canada, 1996, in Vaillancourt & Keith, 2007, p. 40).

Other differences, linked to physiology, include women's greater vulnerability to health problems associated with PSU (Larson, et al., 2005; Lex, 1990 in Roberts & Nanson, 2001; Salmon et al., 2006). Women with PSU are also more likely than those without, to have some mental health disorder, such as depression (Koehn & Hardy, 2007) which is often undiagnosed (Zilberman et al., 2003 in Salmon et al., 2006). Zilberman et al. (2003) found that "as many as two thirds of women who experience PSU report a concurrent mental health problem such as PTSD, anxiety [and] depression (in Salmon et al., 2006, p. 32). Women are prescribed psychotropic drugs at twice the rate of men in North America and Europe (Currie, 2007) for medical and non-medical reasons (Currie, 2007; Sutker, 1981, in Nelson-Zlupko, et al., 1995). In Canada, drugs that are most often over prescribed to women are benzodiazepines (tranquilizers) (BC Centre for Excellence for Women's Health) and antidepressants (Currie, 2007).

Complex connections exist between stress, systemic inequities that women face such as higher rates of poverty, and the multiple roles that women typically fulfill, including a disproportionate share of care giving to children, and ill or elderly family members (Salmon, et al., 2006) and how these factors contribute to mental health problems for women. Because of the highly addictive nature of the drugs, women often become dependent on the very drugs prescribed to mitigate stress-related mental health symptoms (BC Centre of Excellence for Women's Health: Policy Series). Despite the fact that it is widely accepted that the benzodiazepine class of drugs are intended only for short-term use (less than two week periods), they are commonly prescribed for long-term

use in women. Beckwith (1992) presents an interesting perspective on the over-prescribing of sedative drugs to women as a practice that "is a strategy for adjusting women to unjust circumstances" (in Raven, 1997).

These differences illustrate why there is a growing understanding of the importance of acknowledging sex and gender differences in health in general and, more specifically, how these differences relate to substance use and misuse (Poole & Gavin 2003; Salmon et al., 2006).

PSU and Domestic violence

Many studies consider the very complex relationship between PSU and domestic violence. For the purpose of this thesis, domestic violence is defined as:

> "a term [that] does not designate a particular gender, though it has come to be understood as reflecting the dominant pattern of violence towards women. It nevertheless is an inclusive term which highlights the criminal nature of much abuse and refer[s] to both the gendered pattern of violence against women, as well as to other diverse ways in which adult violence impacts upon children" (Humphreys, 2006, p. 13).

Researchers in the UK find that alcohol was a factor in 80% of the incidents of domestic violence and "a very significantly raised incidence of violence in families with a problem drinking parent" (Vellam & Orford, 1993, p. 218, in Kroll & Taylor, 2003, p. 42). US researchers find that in 92% of incidents of domestic violence, drugs or alcohol were consumed by the perpetrator on the same day (Brookoff, O'Brien, Cook, Thompson & Williams, 1997, in Kroll & Tayler, 2003). Specific to female victims of domestic violence is a link between incidents of trauma and violence, and the onset of women self-medicating with drugs or alcohol as a means of coping with the emotional and physical aftermath (Humphreys, 2006). Women are also more vulnerable to victimization when using drugs or alcohol (Humphreys, 2006).

The need to flee male violence is the primary reason for homelessness cited by pregnant women with PSU (Salmon et al., 2006). Women with PSU, residing in rural communities, and financially dependent on partners, describe themselves as feeling trapped because of their inability to access social assistance funds that they need to access treatment, and sometimes leave violent relationships (Vaillancourt & Keith, 2007). This reality is exacerbated for Aboriginal women who are "three times more likely than non-Aboriginal women to die as a result of violence, and are over represented among women admitted to hospital for violence-related injuries" (Public Health Agency of Canada, 1996, in Salmon et al., 2006, p. 32). Poole and Gavin (2003) discuss how these issues all contribute either directly or indirectly to the multiple barriers for women seeking, engaging in, and completing treatment for substance misuse. Some of these barriers are identified below.

Mothering

Two important considerations when discussing maternal PSU in the context of the child welfare system include: the social construction of mothering and the concept of deserving and undeserving mothers; and the dichotomizing of the interest of mothers and their children. With respect to the social construction of mothering, as Boyd and others suggest "the assessment of mothering and proper female roles is integral to welfare policy" (Edwards, 1988; Maher, 1992; Maier, 1992, in Boyd, p 118). Gustafson (2005) refers to the master discourses of the good mother/bad mother dichotomy and states that dominant culture developed the ideal 'good mother' as "the normal and desired state for a woman and female parent. Commonplace cultural images tend to represent the white, middle-class subject as the embodiment of the good mother" (Gustafson, 2005, p 26). The author goes on to describe "the stereotypical image of the bad mother that springs to

mind is the woman who neglects, abuses, or fails to protect her child. A woman who is unwilling or unable to perform her motherly duties is thought to be motivated by selfishness, self-absorption, and self-indulgence - all individual defects" (p 28).

In the context of the child welfare system it is important to consider how the interests of mother and child "have been perceived by the state as separate, and often in conflict with each other" (Kasinsky, 1994, in Boyd, 2002, p 121). This simplification and polarizing of mother and child originates in pregnancy and is perpetuated throughout the lives of mothers and children. Rutman et al., (2000) explain that the issue is presented from a simplistic and dichotomous 'either/or' argument; either the rights of the mother, or the health of the foetus are paramount. Chavkin (1992) affirms this dichotomy and suggests that three social responses emerge in relation to pregnant women with PSU. The first is to charge them with a criminal offence; the second, to monitor them in the child welfare system; and third, is to offer substance misuse treatment (which she identifies as limited and predominantly inaccessible to pregnant women).

Greaves et al. (2002) conducted a qualitative research study of the negative, judgmental discourses embedded in policy and procedures related to women's PSU. They find that these discourses were, to some extent, internalized by the group of women in the study, many of whom had been involved in both the child welfare and Addiction Services (ADS). Boyd (1999) cautions that focusing solely on maternal PSU detracts from the societal stigma against these women, which informs inadequate social policy and funding and further perpetuates their oppression.

The effects of maternal PSU on children. To be comprehensive, any discussion of mothers with PSU must incorporate a consideration of the children of these mothers as

well. Maternal PSU can be detrimental to the physical and mental health of children. These negative, harmful effects can include prenatal exposure to drugs and alcohol and related health and developmental difficulties, as well as emotional, relational, psychological, and physical harm.

A substantive body of literature focuses on the detrimental effects of alcohol ingested during pregnancy on fetal development. Fetal Alcohol Spectrum Disorder (FASD) includes a range of permanent birth disorders associated with fetal alcohol exposure and includes the diagnosis of: Fetal Alcohol Syndrome (FAS); Fetal Alcohol Effect (FAE); partial fetal alcohol syndrome (pFAS); alcohol related neuro-developmental disorder (ARND); and, alcohol related birth defects (ARBD) (Burd, Klug, Martsolf & Kerbeshian, 2003). FASD is often the tragic multi-generational legacy of prenatal substance abuse; approximately 50% of women with children who have FASD, are themselves affected by FASD (Clarren, 2002, in Northern Family Health Society, NFHS, 2002).

With respect to the effects of prenatal exposure to drugs, other than alcohol, a less clear connection is evident between in utero exposure and harm. Neonatal Abstinence Syndrome (NAS) can be due to "intrauterine exposure to heroin or methadone...other less potent opiates have [also] been implicated as causes of NAS...[as well as] non-opiate central nervous system depressants" (Finnegan 1985). Finnegan (1985) defined NAS as "a generalized disorder presenting a clinical picture of central nervous system hyperirritability, gastrointestinal dysfunction, respiratory distress and vague autonomic symptoms" (p 1). NAS can result in withdrawal symptoms in infants shortly after birth (Dore, Doris, & Wright, 1995). Specific to prenatal cocaine use, Boyd (1999) argues

sufficiently conflicting empirical evidence of foetal outcomes put into doubt any conclusive statements about a related syndrome. Others suggest that due to the preponderance of low income women in studies related to prenatal cocaine use, the outcomes resulting from maternal poverty (Myers, 1992 in Boyd, 1999) are not isolated from those related to cocaine use. Boyd recommends that poverty and other variables that affect pregnancy outcomes be included in pregnancy outcome studies.

An Ontario study of children with parents who have substance misuse problems indicates that these children are at increased risk for physical and sexual abuse (Walsh, MacMillan & Jamieson, 2003). Studies show a number of psychosocial difficulties in children of parents with PSU (Dore, Doris, & Wright, 1995). Parental PSU can become the "central organising principle' in a family and create a dynamic of "secrecy and denial, with the resulting confusion, tensions and anxieties that arise, [that] are clearly issues for the children of substance-misusing parents" (Woititz, 1990, in Kroll & Taylor, 2003, p 183). Additionally, a 'conspiracy of silence' can emerge, because of the shame and fear of consequences of people outside of the family finding out. This 'conspiracy of silence' can result in the family isolation from potential sources of outside support such as extended family members, friends, and the community (Laybourn et al, 1996 in Kroll & Taylor, 2003, p 183).

Some variables contribute to difficulties for children with parents who misuse substances, and others mitigate against the negative effects (Velleman & Templeton, 2007). Models that consider resiliency in children, and protective factors in families, could inform a paradigm shift in child welfare work, taking the focus from the deficit-based, risk assessment models of practice, to a strengths-based focus on the family's

functioning (Vellam & Templeton). Vellam and Orford (1993) found that in families with PSU and domestic violence, "children's exposure to the violence was 'severe and regular and often extending throughout a significant period of childhood" (in Kroll & Taylor, 2003, p. 42). Given that the domestic violence is likely to be ongoing in the life of a child, and the high rates of co-occurrence of PSU and domestic violence, it is not difficult to understand how children who witness domestic violence are at risk of emotional harm. "Research consistently shows that children living with domestic violence have much higher rates of depression and anxiety (McClosky, Figueredo & Koss, 1995), trauma symptoms (Graham-Bermann & Levendosky, 1998) and behavioural and cognitive problems (O'Keefe, 1995) than children and young people not living with these issues" (in Humphreys, 2006, p. 20). When these potential harms come to the attention of MCFD in BC, child protection social workers are obliged to assess, investigate and determine the safety of the children in the family.

Child welfare. Due to innumerable variations in statistical record keeping in child welfare agencies in Canada and the US, and a lack of consistent definitions of substance misuse, or abuse, it is difficult to present precise statistics regarding the incidence of PSU in families involved in child welfare services. For example, in the US, researchers' estimates indicate a significant range of familial PSU from 5% - 80% in substantiated cases of child abuse or neglect (Child Welfare League of America, 2001). The Canadian Incidence Study 2003 used a sample of 51 child welfare regions, and recorded findings of child protection reports and investigations over a three month period, (the province of Quebec is not included in the findings) (Trocmé, Tourigny, MacLaurin, & Fallon, 2003). The authors caution that their study has its limitations, but that the findings can serve as a

baseline for future studies. They estimate that in 1998 over 135,500 child maltreatment investigations were initiated, and 45% were substantiated. Of note, from 1998 to 2003 there was a 125% increase in the number of substantiated maltreatment reports, which is attributed to a growing recognition of the impact of exposure to domestic violence, and emotional maltreatment on children, as well as changes to legislation in some provinces. Of the mothers, or female caregivers, in the study, 18 % reportedly engaged in alcohol abuse, and 14% in drug or solvent abuse. Domestic violence was the most prevalent problem for 51% of the women in this study, 40% had a lack of social support, and 27 % mental health issues (Trocmé et al., 2003). Close to a quarter of the sample relied on social assistance, 13% lived in public housing, 28% had moved once in the previous year, and 11% had moved two or more times in the same period. Similar findings have emerged from the US where research indicates an association between families with substance misuse problems, and child welfare involvement in which there is also domestic violence, mental illness, as well as financial and housing instability (Jones, 2004; Semidei, Radel, & Nolan, 2001). Additionally, Jones, (2004) finds that mothers involved in child welfare with both problematic alcohol and drug use, are significantly more likely than mothers with neither to be charged with criminal involvement, incarcerated, and were themselves victims of child abuse. Maternal PSU, particularly among women living in poverty, increases the likelihood of child welfare involvement (Rittner & Davenport-Dozier, 2000; Semidie, et al., 2001; Trocmé et al., 2005); this is especially true for single mothers and Aboriginal women (Blackstock, Trocmé, & Bennett, 2004; Boyd, 1999).

In Canada, a number of factors served to assimilate Aboriginal children into the dominant culture, and dismiss Aboriginal systems of care (Armitage, 1999; RCAP, 1996, in Blackstock, et al., 2004). The primary factors include colonization and the devastating legacy of residential schools, followed by the imposition of child protection legislation. Additionally, "the influence of social worker Euro-Western values and beliefs on their decision making and planning for Aboriginal children and families" (Blackstock 2003; Union of BC Chiefs, 2002 in Blackstock et al., 2004, p. 904), Aboriginal children have been grossly overrepresented in Canadian child welfare systems for decades. In 2003, 40% of the children and youth placed in out-of-home care throughout Canada were Aboriginal (those of Inuit, Métis, or First Nations ancestry) (Farris-Manning & Zandstra, 2003, in Blackstock, et al., 2004).

In 2006 49.6% of all children in the care of MCFD were Aboriginal; a significant percentage given in the same year only 7% of the population of children in BC were Aboriginal (Foster, 2007). The term "in the care of MCFD" applies only to children and youth who have become permanent wards of the state, under legal continuing custody orders. If children involved with MCFD through one of the many other avenues were included in this statistic it would be even higher. The other avenues for children to have MCFD child protection involvement include, but are not limited to the following: a court ordered temporary care agreement; in the care of their parents through a court ordered supervision order; or being cared for in a relative's home via a less intrusive, non court ordered measure. Poverty rates for Aboriginal children in Canada are also significantly higher than for other visible minority groups (Blackstock et al., 2004).

Issues in child welfare practice. Four issues in child welfare practice contribute to the difficulties faced by women trying to manage PSU. Problems with the risk assessment model; the apparent disconnect between the child welfare system and substance misuse treatment services in BC; numerous barriers to mothers seeking and following through with treatment for PSU; the need for child protection and substance treatment services to address these barriers through coordinated program planning, design, and implementation.

National and international literature has stated for years, that child welfare social workers' understanding of maternal PSU must be improved (Dore, Doris &Wright, 1995; Greaves et al., 2002; Poole & Issac, 2001; Semidei, et al., 2001). Boyd (1999) suggests that BC child welfare workers at MCFD maintain a "disease model" understanding of PSU, which assumes that women cannot stop using drugs. White (1998) suggests "child welfare workers' limited professional knowledge of the power relations of their work, and of addiction, arises from the organization of social work education and child welfare training" (p. iii).

Many women with PSU, involved in the child welfare system talk about encountering professionals who have judgemental attitudes towards them (Weaver, 2007). "Most social workers are white, middle-class women making decisions about other families, cultures, and lifestyles" (Almonte, 1994, in Boyd, 1999, p. 133). Boyd (1999) concurs with White in stating that the social workers in her research "typically had little education about cultural differences, drug use, and family formation outside of the heterosexual nuclear family. Their ignorance has negative consequences for women who come in contact with welfare agencies" (p. 133). Based on my work experience in the

child protection system, I argue that neither the education, nor the specific MCFD child protection training that I received, adequately addressed issues of power, race, or PSU. It was in part my own ignorance about these issues that compelled me to continue my education. Other issues to be addressed in the consideration of mothers with PSU and involvement in the child protection system include the risk assessment model used by MCFD, the disconnect between MCFD and addiction services, and barriers to women accessing addiction services.

Risk assessment informed decision-making. The risk assessment model used by child protection social workers, is defined as "a process of predicting whether or not a child will be maltreated at some future point in time" (Jones, 1994, p. 1037, in Rutman, et al., 2007, p. 270). Silver and Miller (2002) explain that risk assessments originated from actuarial science and use statistical computation of identified characteristics common to specific groups of people (in Rutman et al., 2007). Risk assessment models are now widely used in child protection. Specifically in BC, the risk assessment is used by social workers to develop risk reduction service plans. These plans are intended to reflect the workers' expectations of the parent(s). Often, the determination of whether or not to return a child in MCFD care is based on the parent(s) successful completion of the plan. Five studies conducted between 1990 and 1996 present a critique of risk assessments and "suggest that although risk assessment measures appear to be empirical instruments, there is no research-based evidence that they actually predict risk" (Camasso & Jagannathan, 1995; Doueck et al., 1993; Michalski et al., 1996; Pecora, 1991; Wald & Woolverton, 1990 in Rutman, et al., 2007, p. 271). Rycus and Hughes (2003) found that

"the preponderance of research literature continues to raise serious questions about the reliability and validity of most of the risk assessment models and instruments currently used by child welfare agencies. In practice, many child welfare professionals are making decisions about children and families with little more accuracy than flipping a coin, while believing they are using technologies that reduce subjectivity and bias, and that increase the quality of their decisions" (in Rutman, et al., 2007, p. 271).

The risk assessment model used by MCFD is criticized because it requires "a substantial investment of workers' time, training and supervision" (Rutman, et al., 2007, p. 271) and is subject to "uneven implementation" (Pecora, 1991, in Rutman, et al., 2007, p. 271). Another limitation of the risk assessment model is that it is premised on the abstinence model of substance misuse treatment, which expects that one should stop using completely prior to and during treatment (Rutman, et al., 2007). Expectations of abstinence in the face of the realities of problematic substance use is unrealistic, as recovery is a slow process that seldom meets the expectations of the abstinence model (Poole & Isaac, 2001; Rutman, et al., 2007).

A final critique of the risk assessment and risk reduction service plan is that this model fails to acknowledge the contextual realities of most mothers with PSU. Rutman et al., (2007) provide an apt example "that inadequate housing and child care are in fact social issues rather than failures of an individual woman is not reflected or even recognized in the risk assessment and reduction processes" (p. 278).

Disconnect between child welfare and substance misuse treatment. Despite the increasing awareness of the connection between parental substance misuse, and child abuse and neglect (Grella, Hser, & Huang, 2006), a disconnect continues between child

welfare services and PSU treatment services (Humphreys, Regan, River, & Tiara, 2005). In part, some differences between child protection and addictions services contribute to this disconnect, including: organization; underlying philosophies; staff training; and missions or goals (Colby & Murrell, 1998). The disconnect between these services interferes with comprehensive and holistic service provision that adequately meets the needs of families involved in both systems without overwhelming them with a plethora of services and unreasonable expectations. Young, Gardner, and Dennis (1998) identify the paradox "that success for many of the children and families in the child welfare system can only come from working with services and supports from outside the system" (p. 161).

Mothers with PSU, involved with the child welfare system are often mandated to attend treatment while their children are removed from their care and placed in foster homes, or with relatives (Gregoire & Delray, 2001). The challenges experienced by mothers with PSU, including: the barriers to accessing treatment; the need to function in the role of parent; meeting the standards of child protection services with insufficient and inappropriate resources and support, significantly contributes to many women struggling for years (Greaves, et al., 2002; Marsh, D'Aunno, & Smith, 2000; Tait, 2000). This struggle may result in a loss of custody and care of their children. For mothers to succeed in managing PSU and parenting their children, coordination between child protection services and substance abuse treatment programs is imperative (Poole & Isaac, 2001). In evaluative studies of programs for pregnant and postpartum women and their infants, the United Nations Office on Drugs and Crime (2004) found that "inter-agency collaboration and coordination can address issues such as differing service philosophies and

approaches, promoting joint training, sharing of resources and joint planning and in particular, promoting collaboration between the addiction treatment system, the child welfare system and the foster care system" (p. 71). Perhaps the most important and often overlooked need identified in this study is for a "broad and flexible continuum of care, which can support women in entering, re-entering and completing treatment" (p. 71). Essentially recognizing the need to acknowledge treatment as an ongoing process, plan for, and provide services accordingly.

Barriers to treatment. Numerous barriers to accessing treatment exist for women with PSU. For women, these barriers are personal, structural and societal. Personal barriers include: fear of losing their children to child protection services if they self-report a substance misuse problem (Finkelstein, 1994; Minister's Advisory Council on Women's Health, 2004; Poole & Isaac, 2001; Tait, 2000); guilt and shame about their problem; a lack of support from family members; and pressure not to seek treatment (Poole & Isaac; Tait, 2000). Structural barriers include lack of available, accessible services (Poole & Gavin, 2003; Salmon et al., 2006; Sun, 2004); inability to bring children to treatment, or lack of child care (Minister's Advisory Council on Women's Health, 2004; Roberts & Nanson, Salmon et al., 2006; Tait, 2000); and transportation (Sun, 2004). Societal barriers, as previously identified, include poverty, violence and abuse, marginalization (Minister's Advisory Council on Women's Health, 2004), and social stigma against women with substance misuse problems, including stigma from professionals (Boyd, 1999; Salmon, et al., 2006; Vaillancourt & Keith, 2007), and the ensuing social isolation (Salmon et al., 2006; Sun, 2004). Boyd (1999) presents a bleak picture of multiple social systems colluding to regulate and police women with PSU.

These systems include social services (income assistance), physicians, and nurses (Williams & Bruce, 1994), and the criminal justice system (in Boyd, 1999).

In a number of jurisdictions including BC, legislation reinforces the pressure to perform placed on mothers with PSU involved in the child welfare system. Child welfare legislation limits the amount of time that children can remain in temporary care before permanency plans are initiated, subsequently terminating parental rights, making the children permanent wards of the state, and available for adoption (Government of British Columbia, 1996; Semidei, et al., 2001). These timelines are important for the well being of children because they acknowledge the need for children to have continuity in their lives. However, the timelines consequently put added pressure on mothers entering treatment because of the lack of recognition that treatment is a process, and relapse a given aspect of that process.

Addressing the barriers to treatment. While it is acknowledged in the literature that treatment for PSU for mothers must address the underlying issues, and the barriers to their accessing treatment (Salmon et al., 2006), treatment must also address the complex and mutually reinforcing way that trauma, substance misuse, and mental health interact (Salmon, et al., 2006; UN Office on Drugs & Crime, 2004). For women who live in rural communities, the barriers to accessing treatment are often greater due to geographic "isolation, lack of anonymity, affordable transportation and available child care; the gender roles; and the limited personal program resources available" (Aston, Comeau, & Ross, 2007, p. 111). Of particular concern for women who have experienced domestic violence is that perpetrators of domestic violence use their victim's barriers to accessing services to further control or victimize them (Zweig, Schlichter, & Burt, 2002). Many

women living in rural communities face increased risk because they are dependent exclusively on their partners for income, transportation, and housing (Aston et al., 2007).

Treatment programs in rural and remote communities must be flexible in service provision to meet the varied and specific needs of diversity among rural women (Aston, et al., 2007). Emerging changes and innovative programs are being developed to treat maternal PSU. Boyd (1999) identifies two programs in the UK for mothers who use illicit substances; both are based on "social models of care" and report success (Hepburn, 1990, 1993a,b; Siney, 1994, 1995). Examples of model programs in BC (Poole, 2000) and the US show success at helping this population of women be healthy and parent healthy children (Resnik, Gardner, & Rogers, 1998).

Women who are able to maintain care of their children in substance abuse treatment programs are more likely to stay in treatment (Roberts & Nanson, 2000). Research also shows that women who stay in programs for longer periods have better treatment outcomes (Uziel-Miller, & Lyons, 2000). It is evident in the literature that programs that are best able to help this population of mothers are comprehensive, gender-specific, and strength-based in their focus (Carlson, 2006). The expectation that only treating the 'addicted' family member will result in significant and lasting change must originate from the premise that the substance abuse developed in a vacuum. When there is child welfare involvement, due to child abuse or neglect, and PSU in a family, the two permeate virtually every aspect of family functioning, and thus interventions should be family-based and coordinated (Colby & Murrell, 1998). In Prince George, an innovative long-term treatment community, the New Hope Recovery Society at Baldy Hughes, opened in January 2008, and it recently included a family with a young infant. While this

model is not specifically gender-based for women, it is based on a similar community in Italy that experiences significant success in helping people overcome PSU (Fowlie, 2008).

Conclusion

PSU poses a number of challenges for mothers, their children, and the people in their lives who are trying to help them be healthy, in particular when child welfare services are involved with the family. The process of trying to navigate through the child welfare and substance misuse treatment systems can be daunting. The demands often exacerbate challenging life situations for women who are already trying to manage too much, with too little help. Child protection practices that address the multiple personal, societal, and structural barriers to women successfully managing their PSU are needed. Addressing these barriers necessitates a multi-faceted response to changes in service provision at each of these aforementioned levels. This study will elicit the input of some mothers struggling with PSU in order to incorporate their thoughts, experiences and voices into the discourse.

Chapter Three: Research Methodology and Design

The motivation for choosing an exploratory, qualitative, descriptive methodology is presented in this chapter. Included in this explanation are the sampling methods, participant recruitment, and criteria for participation in the study. Quantitative data collected using a demographic questionnaire are presented. Qualitative data collection entailed one in-depth interview with each participating mother, for a total of ten and one interview with a key informant. A detailed description of the data analysis elucidates the procedures followed, including initial coding, identifying themes, compiling themes into categories and memo-writing.

Exploratory Qualitative Research

In part, the impetus for this study stems from the paucity of sex- and gender-specific substance use research in Canada (Dell, 2007), particularly in Northern BC. Much of the research that exists discusses issues related to women's problematic substance use in terms that depersonalize and decontextualize the lived experiences of these mothers. A qualitative, descriptive method of thematic analysis is used to analyze the qualitative data. The study examines the experiences of mothers who are trying to simultaneously: meet the requirements of MCFD, fulfill the expectations of the treatment program they attended, manage their problematic substance use, and regain, or maintain custody and care of their children under the age of 19. This study follows a qualitative approach because giving voice to the mothers in this research is a major objective of the study. As Patton (2002) explains "what people say and the descriptions of events observed remain the essence of qualitative inquiry" (p. 457); making a qualitative approach the most apt for the purpose of honouring these women's voices.

Initial Contact with Participants. Letters of introduction and participant information sheets were mailed to agencies that provide services to mothers with problematic substance use; these included women's shelters, parenting programs, Aboriginal organizations, and early childhood development programs in six communities in Northern BC, as previously defined (see Appendix B & C). Follow-up phone calls were made to ensure receipt of research letters. As requested, service providers who were willing to participate in the study provided written consent to recruit participants from their agencies. Contact persons at the participating agency locations were asked to display posters (see Appendix D) inviting interested mothers to either identify themselves to the agency contact persons, who would relay contact information for willing participants to me, or for the mothers to contact me directly. I provided a cell phone number on the posters for this purpose, as well as my UNBC email address.

I explained the purpose of the research to the women who called and expressed an interest in participating. The women were given the opportunity to ask questions about the research. Each mother was asked to take part in an interview commencing with a brief demographic questionnaire (see Appendix E). The questionnaires were used to gather demographic and contextual information.

It was explained that it would likely require an hour and a half of their time. For interviews that occurred in Prince George, an interview location was secured, acknowledging the need for confidentiality and possibly the women's personal safety, depending on their situation. For some of the women, the agency location where they saw the poster was appropriate for this purpose.

Means of sampling. In addition to the purposive recruiting strategy, snowball sampling was also used to identify study participants (Rubin & Babbie, 2005). The women interviewed were asked if they are aware of any other women who have had similar experiences and were willing to share them with me for the purpose of my research. If any of the women indicated that they knew of others who might be interested in participating in the study, I provided them with my name and cell phone number and asked that they pass the information on to other mothers.

Participants. This study comprises a purposive sample of ten mothers (women who have biological children from ages newborn and older) who self-identify as having involvement with BC child protection services: the Ministry for Children and Family Development (MCFD). Involvement with MCFD, is defined as having been the subject of one or more child protection investigation(s); which necessitates that a child may be in need of protection as identified in section thirteen of the Child Family Service Act of BC. I attempted to include a diverse sample of women in this study, including women: of Aboriginal and, non-Aboriginal descent; of varying ages; who used different substances; and with initial as well as multiple MCFD involvements.

Additionally, the mothers in this study self-identify as follows:

- experienced some difficulty in their lives due to problematic substance use;
- either referred, or court ordered at the recommendation of MCFD, to attend treatment for problematic substance use;
- attended treatment for problematic substance use at least once;
- may or may not currently have custody (defined as legal custody under the British Columbia Family Relations Act), and care of their children;

- have an open or closed MCFD file at the time of the interview;
- must be from a community in northern British Columbia, either rural or urban.

Northern British Columbia communities included in this research are defined as:

- Prince George, British Columbia;
- one other northern British Columbia community, geographically within 250 kilometres north or south of Highway 16. In order to maintain some level of confidentiality, the name of the other community is not disclosed. The community is very small and releasing the community name may contribute to the identification of participants.

I conducted in-depth interviews with ten mothers who fit the criteria above. I commenced two additional interviews but due to errors in screening, it was discovered that these two women did not meet the criteria for the study. I explained the errors to the women and the reason that I could not proceed with their interviews. I thanked the women for their willingness to participate and reassured them that they could keep the honorarium provided. Both women expressed their understanding and the interviews terminated. During the screening process, I informed two more women who indicated an interest in participating in the study, that they did not meet the study criteria.

Interview procedure for participants. Prior to each interview the participant was provided with a participant information sheet explaining the purpose of the research (see Appendix C). Participants were asked if they would prefer to read the information themselves or have the sheet read to them. Providing this choice ensured that any participant who may have had difficulty with literacy was provided with the same

information as those who chose to read the information independently. Participants were invited to ask questions and seek clarification at any time.

I provided participants a consent form to read, or have read to them, and sign (see Appendix F). I also informed participants that they were able to decline answering any question, stop the interview process, or ask that their information be removed from the research project at any time without explanation, or obligation. None of the mothers asked the researcher to remove their information. The participant mothers received a $30 honorarium prior to commencing the interviews. The mothers in this study received honoraria because most of the participants were living in poverty, and the intent was to cover the cost of any expenses they may have incurred to attend the interview, and to demonstrate that their time was of value. The literature concurs that these are valid reasons for providing honoraria to research participants (Salmon, 2007). When the participant signed the consent form the interview process began with the administration of the brief demographic questionnaire. The purpose of the demographic questionnaire was to determine if there were any consistencies, or inconsistencies in the socio-economic, educational, and familial circumstances of the research participant mothers.

In-depth interviews. In-depth, semi-structured interviews are the primary means of data collection because they "provide an open-ended, in-depth exploration of an aspect of life about which the interviewee has substantial experience, often combined with considerable insight" (Charmaz, 2006, p 29). The proposed interview guide, was reviewed and approved by one of my committee members and my UNBC academic supervisor.

The data collected from these interviews, consisting of open-ended questions, offered the research participants an opportunity to tell their stories, providing a rich source of data. Greaves et al. (2002) emphasize that evidence from women mothering under duress is necessary to produce a complete picture of this issue, and inform policy development that truly meets the needs of these women. The interviews elucidate the experience of what was helpful and what has hindered these women's efforts to manage their problematic substance use, meet the requirements of MCFD and either maintain, or regain custody of their children. Participants were asked to make recommendations to improve services provided by substance misuse treatment programs and MCFD. The questions in the initial interview guide focused on the mothers' individual involvement with MCFD, and their subsequent participation in treatment for problematic substance use (see Appendix G). Earlier interviews and the analysis of the data informed subsequent interviews as unanticipated material emerged from the preceding interviews (Charmaz, 2006). For example, the theme of altering mothering identity was not anticipated but reoccurred in initial interviews. This led me to ask questions in subsequent interviews about the women's self-identity as mothers.

The duration of the interviews for the ten mothers and one key informant, ranged in length from :45 to 1:36 minutes, with most interviews exceeding 1 hour. The mothers' interviews took place in two places, a private office at the UNBC downtown campus in Prince George, and a private room in a local women's shelter in Prince George. Interviews in the other small town happened in a local office in that community. The key informant interview took place in the key informant's office. With the consent of participants, I digitally recorded each interview to ensure accuracy. Charmaz (2006)

explains that recording interviews allows the researcher to focus exclusively on the interviewee and guarantees detailed data. Prior to each interview the recorder was tested to ensure that it was functioning properly. Handwritten notes were also taken as a prompt for further questions. All interviews are kept confidential to protect anonymity. I assigned pseudonyms to each participant and these are used in all publications emerging from the study. Through the process of thematic analysis I aggregated information from individual interviews with the others to limit the potential disclosure of identifying information.

Addressing potential risk. I conducted each interview myself, my years of experience working with people accessing social services in various contexts enabled me to work confidently, and competently with persons who are in distress. Throughout each interview, I maintained an awareness of the participants' body language and comments to ensure their emotional well-being was not put at risk. A few of the mothers cried while recounting their stories. I offered the women a break and reminded them that they were not obliged to answer any questions. Participants who showed distress during their interview, were also reminded that they were not under obligation to complete the interview. All of the participants completed their interviews, regardless of whether or not they experienced emotional distress. If the participant became distressed during the interview, I ensured that she had at least one contact number for a support person, or crisis line for her community so that she could have immediate access to support, or request information for counselling services in her community if necessary.

Key informant. The study also consisted of an in-depth interview with one key informant. Initially the intent was to include at least two or three key informant interviews. After the initial interview, I determined that the initial key informant

interview sufficiently served the purpose of validating the categories that emerged in the data derived from early interviews during the analysis. I decided to proceed with my data analysis based on the one interview. The key informant is a drug and alcohol counsellor with many years of experience working with mothers with PSU. The rationale for interviewing a key informant was to use another data source for checking the validity of categories that I identified from the mothers' data. To be clear, the intent of the validity check is to ensure corroboration by another source of the categories identified in the data analysis. I chose a person with years of experience serving this population of women because of her ability to retrospectively consider the stories of the many women she has served. The categories that emerged from the participants' interviews were used to guide the interview with the key informant. Some of the questions are included in the key informant interview guide (Appendix H). The key informant's responses were used to determine if the categories and concepts I identified in the data analysis were common among this population of women, I thought that this particular drug and alcohol counsellor would be an appropriate validity check for my analysis because of her extensive experience working with this population of women.

A letter of introduction (see Appendix I) and key informant information sheets (see Appendix J) were delivered to a treatment program that serves mothers with problematic substance use. The key informant agreed to meet at her place of work and signed the appropriate consent form (see Appendix K). The key informant was told that she was able to decline answering any question, stop the interview process, or ask that her information be removed from the research project at any time without explanation, or obligation.

Processing the interviews. I provided digital recordings of each interview to a transcriber for transcription. Due to workload issues, a second transcriber was hired to complete the work. Both transcribers signed an oath of confidentiality as required by the UNBC Research Ethics Board, to ensure that they would not disclose information about participants (Appendix L). The initial transcriber who worked on the first two interviews, made a few errors in transcribing and these were corrected. The second transcriber is a professional office administrator with significant experience transcribing interviews. Her professionalism is reflected in the accuracy of her transcriptions. The literature shows that there can be inaccuracies and mistakes when hiring transcribers. However, mistakes can be caught and corrected with careful auditing of each transcript (Easton, McComish, & Greenberg, 2000). I initially read through each interview transcript. Then I audited each interview transcript to ensure accuracy. This process entailed selecting random pages of each interview transcript, and confirming the accuracy of the transcripts against the corresponding point in each recorded interview. Additionally, I read through each interview at least twice while hand coding each line of every interview. During the coding process, I also checked the original interview digital recordings when there were apparent discrepancies in the transcripts.

I attempted to contact participants by letter, or phone to offer a copy of the interview transcripts and determine if the participants were willing to participate in a second meeting. The intent of the second meeting with participants was to present some categories and theoretical concepts that emerged from the initial data and have participants confirm or refute that the findings were applicable to their experiences. This process is referred to as member checking and is a strategy qualitative researchers use to

ensure the precision of their findings (Charmaz, 2006). However, my attempts to contact participants for a second time were unsuccessful. In part, the lag time between each interview and my attempts to contact the participants contributed to my lack of success, as in some cases, this lag time exceeded two months. However, program workers informed me that most participants were not accessible due to issues such as lack of stable housing, demands of family, or treatment program requirements.

I addressed risk, with respect to the data collected, as follows: the written and digital recordings of the interviews were kept in a locked filing cabinet in my home office; and the voice recordings were transcribed into computer files. The computer files were password and firewall protected. Since the participants only consented to the use of their information for the purpose of this thesis research, and any subsequent presentations, or publications, the computer files and transcripts will be destroyed three years after I have successfully defended this thesis. Destroying the files will entail erasing the computer files from my computer hard drive and shredding any related print materials. The purpose of collecting this data and generating the corresponding digital voice and computer files is solely to complete this thesis. There is no valid reason for retaining these files once the requirements of this thesis are complete.

Data Analysis. An inductive approach to data analysis is used in this study. Inductive data analysis allows findings to emerge out of the data as a direct result of the analyst's interpretation of the data. (Patton, 2002). Originally, I intended to use a strictly grounded theory approach for the entirety of this research. However, early feedback from my committee members indicated that my study is in fact a hybrid approach. Some steps of grounded theory data analysis are used to guide the analytic process. But the data has

been analyzed using thematic analysis. This study incorporates the initial steps of Charmaz's (2006) approach to grounded theory data analysis. Upon receipt of the interview transcripts, I read the entirety of each. The initial coding process entailed manual line-by-line coding, of each individual interview following Charmaz's (2006) guidelines of using gerunds. Initial coding entails staying close to the data and using actual words and actions of research participants to more accurately reflect their meaning.

Once the coding for each interview was completed the codes for each line of data, in each interview were manually input into a separate Microsoft Word document for each interview. Focused coding was the next step in the analytic process. Focused coding uses the most recurrent initial codes to sort through and synthesize the data (Charmaz, 2006). During focused coding the properties of each category and the corresponding sub-categories are defined and clarified. Focused coding is used to examine and compare participants' experiences, actions, and interpretations (Charmaz, 2006). Once categories were established for each interview, the next step entailed comparing the categories of each interview with other interviews. Each step of this data analysis process, for each interview, is recorded in Word documents. Recording the steps of the processes in separate files facilitates the constant comparative method, and enabled me to revisit the process as necessary. Comparisons of data within each interview, and from one interview to another, were achieved through the constant comparative method of data analysis (Glaser & Strauss, 1967). The constant comparative method requires that one make comparisons between data, codes, and categories (Charmaz, 2006). Revisiting the various steps of the analytic process provides opportunity to refine the parameters of categories, and ensure that the categories are defined by the data. My supervisor checked my initial

categories. Feedback from committee members identified the categories, and the analysis as thematic and not a grounded theory analysis. The categories are, in fact descriptive themes of the participants' experiences, actions, and interpretations.

Memo-writing. In grounded theory research, memo-writing is used to record the comparisons and connections between data, codes, categories, and the ideas that emerge from this analytic process (Charmaz). Memos were kept throughout the analysis to record the researcher's thoughts, and reflections on the data.

Reflexivity. While collecting and analyzing the data for this thesis, I kept a reflexive journal of my thoughts, impressions, and feelings. This journal has served to remind me of my perspective and how it influences what I see and think about the data collected and how I analyze the data. For example, my role as a former child protection worker informed how I would consider what mothers were and were not saying about their experiences of working with child protection social workers, about how social workers made decisions, and about the outcome of their experiences with MCFD. I was cognisant of my perspective and its influence on what I saw and thought. I care deeply about this population of women and the struggles they endure, which is why I undertook this research. I wrote about the personal impact of hearing these stories again after being out of child protection practice for a couple of years. I was reminded of my white privilege, and how I, as an educated, Caucasian women could never really understand the experience of being an Aboriginal woman. In my reflexive journal I consider my feelings and thoughts after an interview.

I left this interview feeling despair, and deep empathy for the women and children of First Nations communities who have survived the seemingly epidemic domestic and cultural violence. The beatings, rape, incest, alcoholism and drug abuse, poverty, lack of hope, inadequate housing, often inadequate water supply, isolation, lack of adequate

health care, educational opportunities, and inequity between those families that have, and those that have not. It reminded me of a woman I once worked with who described being ostracized on her reserve and having to leave because of it.

I am aware that although the analysis is strongly informed by the context of my past experience and perspective, a main objective of mine was to let the women's voices and experiences stand on their own. Charmaz (2006) cautions researchers to seek to know and reflect upon how participants understand their own experiences. As previously mentioned, I also took steps to address the ethical concerns related to working with this vulnerable population of women. I ensured that the women had access to counselling support if necessary. If a woman did become upset during her interview, I occasionally found it challenging to maintain my role as a researcher and not move into my professional role of mental health clinician. My journal entry speaks to one of these experiences.

During this interview, I was conscious of my own fatigue and how I needed to remain present to keep from switching into counsellor mode. It is difficult to hear mom's stories when it is clear that they are deeply sad and wrought with guilt. I had to work to remain in the role of researcher conducting an interview.

Ethics Approval

As required by UNBC, I applied to the UNBC Research Ethics Board to pursue this research. The Board granted permission as indicated in a letter dated September 29, 2008 (Appendix M).

Chapter Four: Findings

The quantitative and qualitative data collected will be discussed in this chapter. A brief demographic questionnaire was used to collect the quantitative descriptive data found in Tables 1 and 2 below. Qualitative data from the in-depth interviews with each of the ten participating mothers was analyzed and organized into themes. The study also consists of an in-depth interview with one key informant. The key informant's interview is used as a means of checking the validity of the themes identified in the analysis of the mothers' interviews. The key informant's interview data is also reflected below.

Demographics.

One of the stated objectives of this research was to gain a rich understanding of the contextual realities of the lives of these mothers and their children who are living in Northern BC. A secondary objective was to consider any aspects of their experiences that are specific to Northern BC. The demographic information gathered provides an overview of the mothers' current demographics. As noted in Table 1, of the ten participants, seven self-identified as being in the 29-38 age range, two in the 19-28 range, and one in the 39-48 range. With respect to education, two participants completed Middle or Junior high school, five completed some high school, one graduated grade 12, and two completed some college or university. Nine participants identified as heterosexual and one as bisexual. Seven participants were single, two were living in common-law relationships, and one was widowed. Four participants reported having a disability, six participants did not. Those with disabilities identified both physical and mental illness, including being HIV positive, hepatitis C, failing liver, bi-polar disorder, depression, and anxiety. Six of the ten participants self-identified as being of First Nations descent and

four of Caucasian descent. Nine participants identified as having an annual household income of less than $15,000, with one exception whose household income fell into the $15,999 - $24,999 range. Only one participant was employed, and this was on an on-call basis.

Table 1 Personal demographics characteristics

		n
Age, years	19-28	2
	29-38	7
	39-48	1
Education	Middle/Junior High school	2
	Some High School	5
	Graduated Grade 12	1
	Some college or university	2
Sexual Orientation	Bisexual	1
	Heterosexual	9
Disability	Yes	4
	No	6
Relationship status	Single	7
	Living common-law	2
	Widowed	1
Ethnicity	First Nations	6
	Caucasian	4
Annual household income	Less than $15,000	9
	$15,000 - $24,999	1
Currently employed	Yes	1
	No	9
If employed, employment status	On call	1
Presently residing in	Prince George	4
	In another Northern BC community	3
	Women's shelter	3

Table 2 Information about Participants' Children

Number of children under the age of 19 living with parent

7 Participants	no children residing at home
1 Participant	1 child residing at home
2 Participants	all of their children residing at home

If children not currently living with mother, where are they living?

Another family member	6*
Foster care	3

* one family had children residing with family members and also in foster care

Qualitative Data

Initially, I identified multiple categories in the analytic process. Ongoing analysis, reorganizing, collapsing and honing of categories, resulted in some categories folding into others and the development of sub-categories. In the final analysis, seven main categories, and eight sub-categories emerged. These categories are:

1. Living with PSU (PSU): coping with multiple challenges/barriers to wellness; living through Indian Residential School (IRS) legacy;
2. Getting worse after the children were taken;
3. Feeling the impact of MCFD involvement: identifying the quality of relationship with MCFD Social Workers; experiencing judgement and racism, and MCFD moving the bar; MCFD deciding who will care for the children;
4. Altering of mothering identity; engaging in self-blame; acknowledging the impact of PSU on children;
5. Mothers lacking necessary support to get A&D help;
6. Recommendations for relational and practical needs from MCFD: needing better communication with social workers;
7. Valuing relationship as important to the recovery process.

Living with PSU. The mothers in this study identified different reasons for their drug and alcohol use. For these mothers, their substance of choice was most often alcohol, and for most, they also used a drug, including crack cocaine, prescription drugs, and marijuana. Women identified a variety of reasons for their substance use including: loneliness; childhood sexual abuse; means of coping with trauma; coping with loss such as death of family members; living within a family where there is multi-generational PSU; and having to assume responsibility for raising younger siblings as a child, due to

their own parents' PSU. Some mothers talk about their experience of growing up in a family affected by PSU. One mother, Zelda, described how as a child she recalls *"seeing alcohol ruin people because my Dad left for drinking too..."*. She recalled not liking alcohol, or understanding why people drank when she was young, but then being surprised that she became an alcoholic herself.

"...We've got a lot of alcohol addicts and had some drug addicts but we're more alcohol addicts pretty much than anything. And I guess from experience, like when I was younger, I was so anti-drug, anti-alcohol that I didn't even talk to people in the family who drank. So it was like a really big shock for me to be walking through the doors of treatment."

Coping with multiple challenges/barriers to wellness. Half of the women identified themselves as survivors of abuse in an intimate relationship. One mother explained that it was difficult for her to find employment in the small community where she lived. Finding and maintaining stable housing was also a recurring challenge for most of the mothers. This point is especially true for those on income assistance, who eventually lose the housing supplement for their children when the children are removed from their parents' care. "*They [MCFD] know I don't have a stable place to stay since I don't have my kids...*" Lucy. Kim described how living in poverty made it difficult to find affordable housing in a safe neighbourhood *"to help me after Detox,... find suitable affordable housing that was not in the Hood, right around the corner from a crack shack. I needed to be out of there and I couldn't afford to be out of there."* Four of the mothers talked about living with serious and persistent physical illnesses that prevented them from working.

For some mothers, their partners played a significant role in initiating, maintaining, and sometimes escalating the frequency and severity of their PSU. Partners would either supply the women with drugs, or buy drugs everyday for their mutual use.

One woman identified her partner as a negative influence on her getting help with her PSU.

"*My partner went to Vancouver to go to visit his family and clean up and I went to treatment,... and of course I was scared shitless,.... And I had my partner telling me it's just a waste of time, it's like jail.*" Kim

Another mother, Zelda, explained how her ex-partner put her out on the street, was feeding her alcohol and using her sex trade earnings to pay for their drugs. Her partner was increasingly violent towards her and was beating her while she was pregnant. She adds "*I'm lucky I still have my teeth*". She explained that although she did get a court order against her boyfriend it did not work to keep her safe.

Living through IRS legacy. Six of ten mothers are of Aboriginal descent. These women talked about the negative impact of the legacy of residential schools on their families and themselves. Kate shared that her grandmother, raised in residential schools, *"had a horrific childhood... ."* Kate explained that there were negative repercussions for her family including her grandmother passing her mistrust of "*white men*" on to her children and grandchildren, as well as a legacy of chronic abuse and illness.

"I couldn't count on my hands family members, I don't have enough fingers and toes that are positive for Hep C... every one of them has been abused. You know, and this is a natural thing in Aboriginal culture, especially down where my mom lives...." Kate

These Aboriginal women talked about how the education and healing provided at First Nations-based programs was important and significant for them. The women felt that their experiences in culturally specific programs provided them with better understanding of their own lives, and helped them to develop a new perspective on their PSU. Lynn learned to reconnect with her Aboriginal spirituality. She explains *"my*

spirituality, being Aboriginal, that was a huge one cause I grew up with Caucasians... most of my life so a lot of that was lost for me..." Lynn

Jane identified that it was very helpful for her to attend an Indian IRS Survivor treatment program with an emphasis on education about the legacy of residential schools on First Nations communities and individuals.

"Wilp Si'Satxw is more of a native healing center... for me it's like I found my spirit again like my spirit has been broken for so many years and I went there to deal with my addiction and I didn't know I'd be dealing with the root of my addiction, which was really good."

The women who identified a family connection to IRS were clear that they wanted different (better) outcomes for their children. *"Because I went through a lot of abuse and I took it really serious that none of my kids are going to feel what I felt because my mom's stepfather took a lot away from me."* Lucy. Participants described how they had lost their connection to their Aboriginal culture as children, and from being "urban", and how culturally-based treatment programs helped to reconnect them to their culture. *"I'm so urban, it's not even funny. And learning some of that stuff... like smudging... and... learning about residential schools, that has a lot to do with addictions because of like generation to generation."* Zelda

Some of the mothers referred to being in MCFD care as children. Lynn explained that the social worker she worked with as an adult and parent had known her from the time she was a youth in care. She felt that the MCFD social workers were judging her more harshly because she was a former child in care (CIC). This mother recalls *"feeling like I was back in foster care again with MCFD having control of me again"*

Getting worse after the children were taken. Getting worse refers to the mother's describing their distress at having their children removed from their care, the

subsequent increase in PSU, and the multiple consequences of the increased use. Getting worse was an almost universal experience described by the mothers, with only one exception. Women identified several serious consequences of their children being removed from their care. Mothers described feeling depressed and grieving for their children, and experiencing intolerable pain at this time.

"I couldn't believe that I let my kids down again, and I felt like a failure and so I admitted myself to the third floor [hospital psychiatric unit], so I could get on anti-depressants... because you know, I was thinking suicidal but I would never attempt it because I have three kids who need me. My father committed suicide I know what that feels like." Jane.

Mothers also described losing their children to MCFD care as the impetus for sustaining their PSU. Sue described her experience of losing the care of her daughter making her drinking *"go monstrous."* Jane described relapsing in response to the disappointment of not getting her children back after completing treatment, as promised by the social worker.

The mothers' perceptions were that MCFD was setting them up to fail by taking their children and leaving them with nothing, no hope, and taking the only good thing in their lives. One mother explained how she felt as though having her own mother care for her children might not have been a good idea. Kim said that she felt it was giving her more *"free range"* because her children were not there. She described going straight back to the crack shack after her children were gone and getting high again.

"I sat there and cried and cried and got high and you know, it was cycle at that point. I used because I hurt and I hurt because I used, so, I couldn't get out of the loop at that point". Kim

The key informant acknowledged this theme of getting worse. She shared that she has witnessed many women caught in this vicious cycle. She explains:

"I mean, just by definition, addiction always wants more, right. It actually goes for this totally out of control place, ...And having children and any kind of structure in your life,... whether it's work, children, any kind of expectations in your life, it keeps that totally out of control thing at bay because you still have to perform.." Key Informant

Abby referred to the experience of losing the care of her baby as breaking her. She described feeling the most pain that she had ever felt in her life when her daughter was taken from her care. *"It's like a death when you lose your children and I stayed numb, I stayed high, I just went on the worst binge I could ever go on to numb out".* Kim talked about not having any idea about recovery, but realizing that the drug had consumed her life. Jane realized that she was using drugs as a coping mechanism, and admitted that she did not know how to cope without drugs.

Feeling the impact of MCFD involvement.

Identifying the quality of relationship with MCFD Social Workers. With respect to their involvement with MCFD, the predominant focus was on the nature of their relationship with the social worker, and/or team leader. The women's experiences ranged from subjective reports of feeling supported by their social workers, to being treated with disrespect. The disrespect reportedly came in the form of negative comments, disregard for the women's competencies and personal strengths in their process of recovery from PSU, and racism. The women also reported feeling as though the social workers' excessively punitive approach was akin to being treated like criminals.

Often the mother's lack of trust in MCFD lead to them initially denying their addiction to MCFD social workers. Mothers described being threatened and forced by

social workers to go to treatment or potentially not be permitted to get their children back into their care.

"So I remember [the MCFD social worker] was a man and he kept always telling me to quit drinking and that if I don't go to treatment I'm not going to see my daughter and all kinds of things like that." Sue

Lily identified that northern social workers in particular, those from Prince George, had a reputation for being disrespectful. Another mother, Kim, described the social worker that removed her children as rude. Kim said that when she told the social worker to go get a court order if she wanted to come into her home the social worker replied "we don't need a fucking court order".

Gwen had a more positive experience of social workers. She said that at a meeting the social worker and her team leader asked her what she thought needed to be done. This exception was only one of two reports of mothers being asked for their own input on their needs. This mother added that she was very impressed with the team leader who came to her home with her children and actually helped her out with something she was unable to do on her own.

Jane talked about being frustrated by the social worker because she felt like the social worker was not hearing her plan. The mother added that this made her feel as though people see 'addicts' as unable to change. Further, the mother felt that in her experience, social workers seemed to view every situation as the same and having a standard response to each family.

A recurring experience for participants was the feeling of being persecuted, as though MCFD was treating them like criminals.

"So I don't know if the way they treat you for the first little bit is like a scare tactic or if it, you know, to rattle you up, or, but I think that in the beginning they could treat you more like a human being instead of, you know, a criminal." Gwen

Jane describes her experience

"I did treatment and I slipped once, and now I'm being treated worse than a criminal, you know I think a criminal does, legally have more rights. And there's nothing I can do about it at this point, there's nothing I can do, but sit back and jump when I'm told to jump, so it's difficult."

The key informant endorsed this theme of mothers' reported feelings of being treated like criminals. She explained that in her experience, women often described feeling like they were being treated like criminals.

Mothers also talked about social workers focusing on the negatives and how that influences the mother's ability to focus on what she has achieved.

" I was like where is the positive in any of this, and you expect me to be positive, when you don't have a positive thing to say to me, it's all negative,...how's a mother supposed to feel encouraged, if you're being discouraged?...Might not be intentionally discouraged, basically what it boils down to." Jane

During a meeting with the social worker and team leader, Gwen describes feeling very angry with how she was treated as though she were invisible,

"...because the team leader talked like I wasn't even in the room and so by the time the meeting was over, my teeth were clenched and I was not very impressed at all. Why did they even get me to go to the meeting? They wasted my time."

She explained that this approach made her reluctant to talk to the social workers because she felt it was pointless because she would just be dismissed.

Experiencing judgement, racism and engaging in self-blame. Jane described how she felt a social worker was judgemental about her circumstances.

"I said to [the social worker] I have a feeling we come from opposite sides of the fence, and she said yeah I didn't grow up on welfare...I think that certain people shouldn't... be social workers if they're going to criticize and look down on people who are living in

poverty... .I didn't grow up and say I want to be on welfare and...I didn't grow up and say I want to... be a crack head...it's discouraging when there are social workers out there...that shouldn't be even working in this line of work cause they have the potential to ruin lives as opposed to helping."

Mothers expressed feelings of coercion by MCFD; in particular, Lynn, who had been a child in MCFD care explained *"I felt like I was back in foster care almost, you know, like they were over top of me again, had control of me again."*

In reference to her experience with MCFD as an adult, she engages in self-blame, stating that it was her fault because she was *"agreeing with things I shouldn't have with MCFD."* Lynn thinks that in hindsight, she should not have agreed to certain things: going to treatment,, attending parenting courses, participating in different types of counselling. For Lynn it was more a feeling of being coerced, she explains, "...I'm 35 years old now and I look back and think, I know they treated me as a child at 21... more as a child than like a mother, or a person,"

The issue of racism was identified by a few of the mothers and in the opinion of Lily, MCFD is deliberately focusing on single Aboriginal mothers in her community She explains:

"Like these people from (small northern community) the ministry's taken a bunch of single mothers, all them kids been removed...only single mothers, ...they're all native girls...all their kids been removed from them and I was one of them, and it's so hard,"

MCFD moving the bar. 'Moving the bar' emerged as an early category which reflects the mother's experiences of finding out about MCFD expectations, and then when they are beginning to engage in fulfilling those expectations, feeling as though the social workers arbitrarily impose additional expectations. The mothers described feeling that they really did not understand what was expected of them, that the social worker was

"giving me the run around. I do their things, and then when it comes to the end of that string, they find something else to keep my kids." Lily

Mothers also indicated that they did not have a good understanding of the court system or MCFD procedures, such as family group conference meetings. Mothers reported feeling overwhelmed by MCFD expectations, and thinking that social workers make many, and unreasonable, demands of them.

Additionally mothers described how they felt when they completed some of the mandated expectations, but the social workers do not acknowledge their accomplishments. Mothers described feeling as though the social workers overlook what the mother's have done, and are only focused on the negatives, or the expectations that have yet to be fulfilled.

"I haven't heard a positive thing coming from her, there's no positive, it's all negative and, she said that's her job, and I don't agree with that. You know I did treatment, I passed treatment and she said oh your next step is..., not congratulations, good for you...." Jane

The result is that mothers start to feel as though nothing that they do will be good enough for the social workers. These types of experiences led some mothers to mistrust social workers and their team leaders.

Another common experience for mothers involved with MCFD is having more than one social worker to deal with because of the frequent turnover. As the key informant noted, involvement of a new social worker with a family could also result in "moving the bar". Because of the element of subjectivity in professional practice, some social workers may take a more punitive approach than others, thus changing the expectations of the parents. The key informant explained that *"this is not an unusual experience."*

MCFD deciding who will care for the children. Over the past decade, MCFD's shift in mandate to place children with family members whenever possible has significantly changed practice. One woman explained that MCFD committed to placing her children with other family members; however MCFD did not follow through. While some mothers were involved in the process of deciding where and with whom their children were placed, other mothers had no say in the experience and felt as though they had no control. One mother explained that all of her children were living in different homes, some with family members, one in foster care and one had been adopted out. Essentially, this mom was feeling a degree of resignation and questions foster care standards. The mothers refer to being overprotective of their children and identifying the connection to their own childhood experiences of abuse either sexual or physical. Lily, in particular though has a lot of respect for, and trusts the foster parents that are caring for her children.

Sue explained that despite social workers' efforts to speak to her she was refusing to talk to them. Sue spoke candidly about her own responsibility in the lack of communication with MCFD. She explained that her avoidance of the social workers was motivated by fear and anger. She was fearful of what the social workers wanted to talk to her about, and concerned that it might be a request for her to relinquish her partial custody of her daughter so that her mother would have full custody.

Acknowledging the impact of PSU on children. PSU has significant consequences in these women's lives, including deteriorating relationships with family members, incurring criminal charges, and sometimes serving time in custody. Often, recovering from PSU is a lengthy, involved process that can take several years, as

evidenced by Sue's comment that she was able to stay clean for over two years and then started using again.

When Sue's daughter was taken into MCFD foster care she wanted to see her daughter. However, their visits actually made it worse for her and her daughter. She recalled dreading the visits with her daughter because her daughter would not want to leave her mom when they were over and she would be crying. This mother was candid about the fact that she had very liberal access to her daughter once her daughter moved from foster care to her grandmother's care. Sue explained that she may have actually gone to treatment sooner if her daughter had stayed in MCFD care because she would have had significantly less access to her daughter.

Kim talked about how her depression lead to cocaine use and interfered with her ability to meet her children's basic needs. She talked about feeling so guilty and having to answer to her children for those decisions. Jane talked about feeling tremendous guilt and knowing that nothing will take the guilt away for her. Jane feels shame for using while pregnant and knows the shame will never go away, she identifies wanting to remember the pain so that she will not make the mistake again. *"I know I made mistakes, and I feel terrible because my children are paying for you know, my mistakes. You know I.. it's very upsetting to me".*

Some of the mothers eventually acknowledged the need for MCFD involvement. *"I love child welfare. I love the fact that they can speak for babies that need to be spoke for..."* Abby

"Now when I look at it I'm glad somebody intervened because... I shouldn't have been drunk at that time of the morning...so I'm kind of glad it played out that way." Sue

"...I was very angry... but at the same time... I was a little bit relieved because the mom in me said I knew I was fucking up really badly and I wanted more for my kids than what was going on..." Kim

Altering mothering identity. All of the women talked about the good work that they had done parenting their children at some point. They identified their capacity to parent and in doing so, were affirming their own parenting ability. Some of the women also spoke to their very strong connection with their children, and the importance of their parenting role to their self-identity. Lily explained,*" I was pregnant and... I stayed sober all the way through the pregnancy...". "I'm nothing without my kids"*. Jane clearly identified her children as the best thing in her life. Kim spoke of her parenting ability and identified herself as being a really good mother.

Several mothers spoke about not trusting anyone else with care of their children. These mothers talked about being overprotective of their children and made the connection to their own experiences of childhood abuse.

The mothers also talked about the "bad parenting" message that they were getting from MCFD social workers. They began to internalize the bad parenting message and this presented a shift, or change, in their self-image as good parents.

"Because [MCFD] seem to expect the worst... and when you expect the worst, you know it's like self talk, you tell yourself, I'm bad, I'm bad, and this is where the Ministry comes in, I'm such a bad parent you know you start to believe it." Jane

A number of the women talked about feeling discouraged by judgemental social workers. They also shared that their experiences of working with MCFD social workers left them feeling powerless. *"...when I look back is what I'm telling you is I don't think I've been connected, like they've really treated me like, like a mother, like a parent. They've always looked at me as a fuck-up is what I mean..."* Lynn

Abby shared her thoughts on what she thinks mothers need from social workers, *"I think working with them and helping them and making them feel like, you know, they're not bad people. Like you get that message a lot like you're a bad mom and you're really fucked up."*

Lacking necessary supports to get A and D help. According to seven of the ten mothers, MCFD social workers did not provide contact information for drug and alcohol counsellors, nor did the social workers make a referral to a drug and alcohol counsellor or treatment centre. Sue remembered seeing a paper from MCFD telling her to go to treatment. "*I remember the paper specifically, it said that I needed to go to treatment. It didn't tell me what resources to go to or nothing. That's why it was so complex...*" The mothers also reported that the professionals that they were working with were not communicating with each other. Lily had a similar experience *"[MCFD] didn't... give me any contact information with anybody,... I asked and they never gave me names."* Lynn recalls getting a referral to a drug and alcohol counsellor from the staff at detox, and subsequently getting a referral to treatment from the drug and alcohol counsellor. The mothers identified not knowing how to get treatment and needing help with the process, but not knowing where to turn for help.

Kim explained that she did receive a risk reduction service plan (RRSP) but that the social worker did not provide contacts in the plan.

"She just said that this is what I want you to do in the risk reductions plan. I signed it and it was up to me to do them and she didn't give me any phone numbers, didn't suggest any agencies..."

Mothers also reported that social worker and drug and alcohol counsellors were not working together. *"My drug and alcohol counsellor did it on her own pretty much*

because like I talked to her about everything and... my social worker wasn't actually doing much for me... " Zelda

Both of the mothers in the smaller northern community were referred directly to counselling in their home community and were not mandated to go to treatment. The social worker actually made the appointment for Gwen at the counselling centre. Gwen also had an exceptional experience in that she felt the social worker had made expectations regarding the counselling appointments very clear; for example, any missed appointments would have to be rescheduled.

In terms of understanding the process, Jane clearly understood her right to confidentiality. She signed release forms 'everywhere' to consent to workers sharing information about her progress. Other mothers also referred to information sharing between social workers and alcohol and drug counsellors. "*The counsellor was obligated to report that I am coming... [and] what we basically touched on but they didn't have to go into any details about it. So that was nice too.* " Gwen

Recommendations for relational and practical needs from MCFD. When asked what would make the experience of involvement with MCFD better or easier for mothers, the response was predominantly related to the quality of relationship, and the communication, with the social workers. Gwen explained what a number of mothers identified as the paramount barrier to relationship with their social workers,

" *[MCFD social workers] have to be suspicious; they have to assume the worst to get down to the bottom of it. But at the same time, it makes the process even harder. It would be nicer if they just treated you like a human being to begin with...you don't want to talk to somebody that puts you down... it makes you more reluctant to even talk to*

them... because you know every single time that you talk to them, you're being put down further. And people that do have really serious substance abuses, that's the last thing that they need. They need encouragement that they can be good people. And in the first little bit, you don't get that encouragement that you can be good people. You're just a bad person."

With respect to what they need from social workers, Jane said:

"Positive support... I can't stress that enough, positive support from a social worker, umm, giving someone the benefit of the doubt you know, I ... I made a mess, I screwed up, but give me a chance you know? Just because I screwed up, doesn't mean I'm always going to."

Most of the participants talked about how their conflictual relationship with their social workers served to undermine their progress. They attributed some of their reluctance to engage with punitive social workers to the fear that any disclosure, or acknowledgement of lapses, an incident of substance use would be used against them getting their children back.

"*I never felt I could tell [the social worker] because I always felt it would be held against me, with my children... but at treatment I could... start to get those things off my chest and not have the resentment there anymore about it."* Kim.

The key informant identified this barrier to honesty in the parent-social worker relationship as detrimental to a woman's progress in recovery. The key informant explained how lapses are a normal and expected aspect of drug and alcohol recovery. The women in the study report that when they had a lapse, it was used against them in determining the relative safety of their children in their care.

Jane spoke of a lapse and her need for the social worker to understand that one lapse does not always lead to a full blown relapse, or return to their problematic PSU. The key informant corroborated that, in her experience, social workers need to have a

better understanding of addictions in order to mitigate against perceiving risk to be much greater than it actually is.

"I've often found myself in the role of advocate as the addictions counsellor, pointing out... okay, there was a lapse but there have been two months clean and a really good contact with the children... But I do understand how it would happen, so like it's already sort of putting me more in mind of solutions maybe like the education that possibly would be needed for child protection workers." Key informant

The point that social workers need more knowledge of, and education about, addictions was reiterated by a few mothers. Abby explains her view, *"So I think if you're going to be in that field, Child Welfare... they need something other than a textbook education. Red eyes and glossy eyes are just not a sign of being high."*

Several mothers identified that they wanted social workers to treat them with more respect, and acknowledge the mother-child bond. *"I'd want them to know to have respect when you're tearing a child away from a mother, have respect that mother really loves that child and the child loves the mother and be respectful of that.."* Sue

The need for social workers to have reasonable expectations was identified by the women.

"And I felt like kids were used as a... like something dangling in front of something, you know, like you can have them if you do what I say and you mess up on one thing and you don't get them at all." Abby.

The key informant speaks to this as well, *"...no parent could make it under that scrutiny,... there are no perfect parents..."*.

Needing better communication with social workers. Every woman spoke of needing better communication with social workers. Some talked about needing social workers to be absolutely clear about their expectations.

"Like I asked them what do you guys want from me... I said because I've been doing the best I can possibly do and I had my baby and you took her away... so obviously I wasn't doing something right. I said so of course I'm going to ask you guys to put it in writing or tell me, I said I'm really good at following rules... but I need you guys to tell me. And they said do whatever you need to do to stay clean and sober." Abby

Mothers repeatedly emphasize the need for clarity and more information from social workers. The mothers did not understand what social workers were asking of them. *"Explain things. If you want them to go to treatment, show them how. Tell them. Give a clear picture of what you want them to do."* Sue. Implicit in Sue's statement is that when mothers are overwhelmed with the stress of MCFD involvement in their lives, and dealing with PSU, social workers need to be explicitly clear and concise in the information that they provide to women. According to the mothers, some social workers seem to assume that women will know how to proceed with accessing treatment services when in fact at initial involvement some have had no experience with addiction services and have no idea how to access services.

The key informant found it surprising that women mandated to treatment by social workers would not be receiving referral information to alcohol and drug counsellors, or treatment centres. She stated

"when it comes to women who are mandated, I guess I always assumed that the people who were mandating them would refer them,... they would be bridging that gap... they would just be sent off without that information. Actually it's mind-boggling, but it could happen...." Key informant

Valuing relationship with counsellor as important to recovery process. When referring to their relationships with the staff at the treatment centres they attended, or their alcohol and drug counsellors, they reflected on the importance of the support and encouragement they received. The participants attributed much of their own success in

managing their PSU to the assistance of their trusting relationships with their alcohol and drug counsellors.

The mother's were clearly emphasizing their relationships with staff as being important to the process of learning. The mothers were also expressing appreciation for the counsellors accepting that people in recovery make mistakes, and also the counsellors acknowledging the mothers' abilities. Mothers expressed appreciation for alcohol and drug treatment staffs' ability to use humour, and encouraging them through the treatment process,

"The counsellor was very encouraging to me... positive feedback... for the success.. it would make a difference if they spoke to the Ministry but, in some cases, I don't think it would matter.. I think it would totally depend on the worker." Jane

The women appreciated the counsellors who were in recovery themselves because they felt these counsellors had first hand knowledge of their experience. The women attributed credibility to these counsellors, and the counsellors served as an example that PSU could be overcome;

"It was this guy, he used to drink Listerine... underneath those bridges and he was a counsellor there... I couldn't believe that. He really knows what it's like to be like down and out. He would teach us our night classes and I really looked forward to those... he gave me a lot of inspiration." Sue

Mothers also identified the following aspects of treatment as helpful: access to family treatment; treatment programs that were significantly longer than six weeks; clear information about what treatment can and cannot provide. A mother who had the opportunity to attend family treatment with her children explained that the centre provided counselling services to her children at the treatment centre. The mother thought that this was important and helpful for her children. Although this woman's experience

was an exception among these mothers, other mothers identified the need for family treatment, and help for their children.

Some mothers explained that they found treatment programs were typically not long enough in duration and they wanted to stay in treatment longer than six weeks. The women also expressed a desire for social workers to explain that completing treatment did not necessarily result in complete recovery from PSU. These mothers talked about being lead to believe that they would be completely well after treatment and their children would be returned. A few mothers talked about multiple attempts at treatment. Sometimes they would leave treatment and relapse, other times they would complete treatment, remain clean and sober from substances for a period of time before relapsing, then eventually return to treatment.

A few of the women talked about Alcoholics Anonymous not working for them. Sue said that attending meetings was difficult for her. This same mother did find a relapse prevention group to be helpful for her. She shared that her counsellor explained to her that when it comes to recovery, different people have different needs and sometimes it takes a while to find what will work for yourself. This woman explained that for her, in the process of recovery, she has learned that she requires more than one source of support.

Conclusion

The seven main categories and eight subcategories that emerged from the data, reflect the experiences and voices of the mothers from the context of their lives, through their involvement with MCFD. The women identified how these experiences altered their identities, and how they experienced difficulties accessing necessary supports for their PSU. The mothers were able to identify clearly some practical and relational needs from

MCFD social workers. The mothers also articulated that they highly valued their working relationships with drug and alcohol counsellors because of the respect and support they received.

Chapter Five: Discussion

My research question is what is the experience of mothers with PSU when attempting to simultaneously meet the expectations of MCFD child protection services and treatment services for their problematic substance use?

The main objectives of this research are as follows:

- to provide mothers with problematic substance use and child welfare involvement the opportunity to relay their experiences of their MCFD involvement;
- to gain an understanding of the contextual realities of the lives of these mothers and their children who are living in Northern BC, and consider any aspects of their experiences that are specific to Northern BC;
- to ask these mothers to make recommendations based on their experience of involvement with these systems;

The first two objectives of this study have been met in that the women who participated graciously shared intimate and often painful details of their experiences for the purpose of this research. The participants explained that they were doing so in the hopes that their stories may provide insight into what changes could make child protection and ADS experiences better for other mothers who may find themselves in similar circumstances in the future. The third objective was also met. The mothers' recommendations based on their own experiences of involvement within these systems are included in the relevant sections below. The women identified what is needed to enhance service provision and what they value as important to recovery.

Contextual Realities

The contextual reality of the participants' lives brings to mind the term 'blaming the victim' for the circumstances of their lives. This population of women typically experience a deficit of social determinants of health that contribute to a state of personal well being, such as full and fair employment, affordable housing, and access to health care (World Health Organization, 2010), Six of ten women in this study are Aboriginal. In addition to the challenges identified above, Aboriginal women experience racism, and other negative effects related to the Indian Residential School (IRS) experiences of family members. Some of these negative effects are identified in a description of Indian Residential School Syndrome,

"...[an] often diminished interest and participation in [A]boriginal (sic) cultural activities and markedly deficient knowledge of traditional culture and skills...as might be the case for anyone attending a boarding school with inadequate parenting, parenting skills, are often deficient. Strikingly, there is a persistent tendency to abuse alcohol or sedative medication drugs, often starting at a very young age (Brasfield, 2001:79, in Corrado & Cohen, 2003, p 23).

Feminist therapist, Van Den Bergh (1991), identifies alcohol and drug abuse in oppressed groups as a means of coping with their sense of powerlessness. Oppression is embedded in the experiences of mothers with PSU. The women in this study talked about their sense of powerlessness because of their MCFD involvement. Most of the Aboriginal mothers in this study also identified intergenerational PSU, multi-generational MCFD family involvement, and intimate partner violence as significant barriers to their own wellness, and that of their children.

Getting Worse

Getting worse refers to the seriously negative consequences that result from MCFD removing children from their mothers' care, and the mothers' subsequent

increased PSU. In the findings chapter, the women described experiencing a profound sense of grief and loss, resulting from the removal of their children. Consequences resulting from this grief can include the development, or worsening of, serious mental health problems, such as suicidal ideation and depression. Women also report increased PSU as a means of self-medicating to mitigate the pain, then consequently feeling more pain and the shame associated with continued use. The cycle can go on for months or years, with prolonged periods of sobriety between relapses. Some of the mothers' multiple attempts at drug and alcohol treatment reflects the severity of their PSU, and the complexity of the multiple challenges associated with their ongoing struggle with PSU. As mothers articulated, when their children were removed they had no responsibility and no obligations that required them to cut down on substance use or stop using altogether. The continued drug use not only results in pain for mothers, but also a decrease in, or loss of contact with their children. The loss of contact with their children was an extremely painful consequence for these mothers who acknowledge that their relationships with their children are very important in their lives. Despite the mutually harmful effects of separating children from their parents, MCFD continues to use this approach to dealing with maternal PSU; removing children from their parents' care and mandating the parents to treatment. Current MCFD practice standards call for starting from the place of least intrusive measures to mitigate risk to children. Some developments in child welfare practice include less intrusive measures. These developments include: alternative dispute resolution like mediation, aimed at resolving child protection matters with families outside of the court system; family group conferences, which provide families the opportunity to have voice in planning for their children; and differential response, which

considers alternate responses to protection cases (McKenzie, Palmer, & Barnard, 2007). Initiatives such as these facilitate progress towards addressing the practical needs of mothers involved with MCFD. Alternate approaches to child protection practice can also provide more opportunity for communication between social workers and parents. Increased communication can in turn improve the working relationship between social workers and parents. Dominelli (2002a:7, in Payne, 2005) speaks to the importance of feminist social work practice creating egalitarian client-worker relationships to address structural inequalities. The mothers' clearly spoke of the need to be heard by their social workers. More opportunities for the two parties to communicate, will increase the chances the women are heard. However, as identified by the mothers in this study, the communication must be respectful, clear, and include some positive acknowledgement when merited.

Two programs in BC show success in working towards keeping children with their mothers who struggle with PSU. These programs provide essential, timely, and relevant support to pregnant women and mothers with young babies, aimed specifically at managing risk associated with PSU, through use of a harm reduction model (Poole, 2007). The programs are the Sheway outreach program in the downtown Eastside of Vancouver established in 1993, and the Fir Square Combined Care Unit at the BC Women's Hospital. Both programs use multidisciplinary teams, have a strengths-based focus, and practice with an understanding of the context and complexity of these mothers' lives (Poole, 2007).

Feeling the impact of MCFD involvement

Identifying the quality of relationship with MCFD social workers. In attempting to work with MCFD social workers, mothers sometimes experienced support, and reported having good working relationships with their social workers, but more often reported being subjected to threats, disrespect, judgement, and racism. This range of quality of relationship with MCFD social workers was identified in another qualitative study involving MCFD social workers (Weaver, 2007). It is reasonable to expect that there will always be variations in how individual social workers practice, even when guided by an ethical code, standards of practice, law, and the mandate of their employers. However, it is also reasonable to expect that social workers will at least practice with a basic standard of professionalism and respect for the people with whom they work. The mothers talked about expecting to be treated with respect, and questioning whether some of the social workers they dealt with should be working in the profession. Mothers' working relationships with MCFD social workers are of vital importance, and how women are treated can have a profound impact on their identities as mothers, their willingness to engage with MCFD, and their work towards recovery from PSU (Weaver, 2007). Stokes and Schmidt (2010) note that current practices in child welfare do not value the skills that workers need to create effective working relationships with their clients. Weaver (2007) working out of the UBC School of Social Work, developed a training program to address many of the relational problems experienced by social workers with the aim of improving the quality of the mother – social worker relationship. Many of the relational problems addressed in the training program are those identified by the mothers in this research.

The mothers were very vocal about the predominantly negative focus of MCFD social workers. Of particular frustration to participants was the social workers' apparent inability to see the positive steps that mothers were taking to address their PSU and mitigate risk to their children. The mothers felt that social workers viewed them through a negative filter, and consequently they felt unfairly scrutinized, an experience that is corroborated in other studies. For example, Ayre (1998) looked at social workers' decision-making processes in child protection cases, and found that social workers predominantly focused on negative aspects, or weaknesses, presented in case studies. Rutman, Callahan and Swift (2007) argue, and I concur, that this underlying negativity specifically in BC, may in part be due to a push towards a managerial approach to social service provision. The risk assessment model that informs BC child protection practice was implemented to further the managerial approach and standardize practice. MCFD social workers are required to use the model as part of a child protection investigation, to assess the level of risk to children. This model guides child protection practice and focuses on parental deficits, or problems, with little attention to parental competencies or strengths. The risk assessment model may also contribute to the Aboriginal mothers' subjective experiences of racism. Rutman, Callahan and Swift (2007), consider the middle class, Euro-Canadian cultural assumptions that have informed the development of the risk assessment model, and corresponding child protection practice. This model stands in contrast to the values, beliefs and parenting practices of other racial and cultural groups. In particular, the risk assessment model essentially ignores the reality of the historical impact of colonization of Aboriginal peoples in Canada, and the stark poverty in which many Aboriginal peoples live, on and off reserve. Child welfare statistics back

up this argument. When the risk assessment model was introduced to child protection practice in BC the number of Aboriginal children in care rose approximately 17% over an eight year period, and this number has continued to increase since 2006 (Foster & Wright, 2002, in Foster 2007). Aboriginal children are nine times more likely to be in MCFD care than non-Aboriginal children (Foster, 2007), and twice as likely as non-Aboriginal children, to be removed from the care of their parents after a child protection investigation (Wright, 2005, in Foster, 2007). There is need for implementing a gender-based analysis into child protection practice. Policies, programs, decision-making processes that are informed by a gender-based analysis are more likely to address the inherent inequities these mothers experience in accessing services to manage their PSU and parent their children.

Moving the Bar. Mothers experienced MCFD social workers 'moving the bar' regarding expectations; making it difficult for them to have a clear understanding about what they were required to do to maintain, or regain, care of their children. This experience may in part be due to the complexity and frequency of changing circumstances for mothers with PSU. However, mothers tended to perceive it more as a deliberate lack of clarity from MCFD social workers, further contributing to the women's fear of, and lack of trust in their social workers. Rutman, Callahan, and Swift (2007) note that the risk reduction service plan (RRSP) developed to address the risk identified in the risk assessment process, is based on an abstinence model of recovery, fails to recognize recovery as a long-term process, is formulaic, and fails to acknowledge lapses as an anticipated part of recovery. Rutman et al., (2007) explain how the RRSP, presented as a "to-do" list that continues to grow, leaves parents feeling demoralized about their

perceived lack of progress. The mothers in this study clearly expressed this frustration, one of them explained that it felt as though the social workers were "*giving me the run around*"; this sense is particularly evident when mothers did not regain the care of their children upon completion of what they understood to be the expectations in their RRSP.

MCFD deciding who will care for the children. When deciding who will care for the children, if not the parents, mothers felt that MCFD dismissed their parental authority and intimate knowledge of their children.

Altering of Mother Identity. One significant consequence of living with the barriers to wellness as identified above and dealing with the predominantly negative experiences with MCFD social workers, was what the mothers described as altering of their personal identities as mothers. Women reported internalizing the negative messages that they heard from professionals, including social workers, an experience that is reflected in other research (Salmon, et al., 2006). Additionally, mothers shared how they felt discouraged by the social workers' judgemental approach.

Mothers talked about their parenting ability, having strong connections with their children, and not trusting others with the care of their children. Yet they often felt the social workers dismissed their abilities as parents. From a feminist social work perspective, dismissing these women's parenting ability further reinforces the women developing of an external locus of control. The mothers' sense of competency is further diminished when it is devalued by a powerful "other", namely MCFD.

Lacking Necessary Support to get help from ADS. The participants acknowledged the need for some form of child welfare intervention to address risk to children associated with maternal PSU. However, mothers identified a lack of necessary

support to get access to Addiction Services (ADS), such as referrals from MCFD social workers. Despite MCFD practice guidelines outlining MCFD social workers' role in the referral process. A *Protocol Framework and Working Guidelines between Child Protection and Addiction Services* (Addiction Services, 1999), states that the responsibility of social workers includes, but is not limited to: familiarity with the ADS System of Care and referral procedures; familiarity with the model of change and techniques that ADS workers use; clarity about the purpose of the referral, either for assessment or treatment, or both; ensuring that the client understand the purpose of the referral; and obtaining client consent for sharing of client information between the service providers. Current legislation and new MCFD practice standards and guidelines supersede some aspects of this framework; however its existence reflects an awareness of the need for social workers to have knowledge and clarity about addictions issues and services, as well as the ability to make appropriate referrals and articulate the need to clients. It is unclear from this research if the absence of appropriate referrals for ADS were due to lack of social workers' understanding their responsibilities, or other possible reasons, such as excessive workload demands getting in the way of a thorough and appropriate referral process.

Another significant problem for mothers' was what appeared to be MCFD social workers' typical, and disproportionate response to maternal PSU. Several of the mothers in this study were mandated by MCFD social workers to attend residential treatment, in the absence of some form of drug and alcohol use assessment. Drug and alcohol assessments are used to develop proportional responses to each mother's specific need for ADS, alcohol and drug residential treatment program, or some other services. The two

mothers from the smaller community in this study were exceptions in that they remained in their home community, and accessed ADS while residing in their homes. They were also exceptions in their experience of being permitted to resume parenting their children shortly after initial child welfare involvement. As the key informant pointed out, as much as possible within the parameters of the child protection mandate, it is important that the mothers' recovery not take them from other important aspects of their lives, such as their parenting role. As previously noted, the parenting role requires that the mothers maintain some degree of routine and structure in their lives that necessitates a reduction, or cessation of their substance use.

According to MCFD practice guidelines for assessing parental substance use as a risk factor in child protection cases, when appropriate, social workers should be involving others in developing the Risk Reduction Service Plan (RRSP). In particular, the addictions counsellor should be involved in establishing goals for the RRSP (Addictions Services, 1999). This type of collaborative team approach to service provision could facilitate a mutually beneficial understanding between MCFD social workers, and drug and alcohol counsellors. Improved collaboration and information sharing could also potentially lead to social workers becoming increasingly comfortable with the reality that lapses are an expected part of recovery, and not necessarily predictive of a full blown relapse. Acceptance of this reality may result in MCFD social workers taking a less punitive and reactive response to relapses, such as limiting, or cancelling mothers' visits with children, or removing children from the care of their mothers. It is possible that a collaborative approach to RRSPs that includes the ADS counsellor, could address the real

potential for a lapse and incorporate safety plans that could be implemented to mitigate potential risk to children during their mothers' lapses.

Recommendations for relational and practical needs from MCFD

Mothers were able identify for themselves, the practical and relational needs from MCFD that would make MCFD involvement in their lives more effective at providing necessary support, and addressing any real risk associated with their PSU. In terms of practical needs, the mothers explained that there were certain practices that not only improved their self-identity as mothers, but also enhanced their relationships with their social workers. Lily relayed her positive experience of a family group conference (FGC). Although the purpose of the FGC was to determine a long-term plan for her children should their mother not be able to regain custody of them, it was still a very useful process for enhancing the relationship between the social worker and the mother. The mother described it as a self-affirming experience. The mother identified that it was usually only the social worker and team leader's opinions that mattered in the decision-making, but that she felt it was different with FGC because her family, including her children had the opportunity to speak to who she was to them.

As identified in the findings chapter, the quality of the relationship and communication with their social workers were the predominant foci. The bad person, or bad parent message, that women feel they get from the social workers was cited as most harmful. Women identified their need for positive support from their social workers. Some service providers honour the client's needs by acknowledging them as paramount, and making them a priority. Leslie (2007) refers to "growth-promoting relationships" used in the Toronto-based, Breaking the Cycle program, that provides maternal-child services to women who use substances; the key elements identified by the mothers in the

program as important, were "acceptance, empathic understanding, honour, respect and empowerment, caring, love and hope." (p 241). This program is "relationally emergent, evolving experience that reflects the voices of the women and children it serves." (p 242). The program also incorporates outreach workers and links between previously disconnected services. This program demonstrates that it is possible to address both relational needs, and practical needs through bridging between services.

Honesty is fundamental to recovery from PSU and women need to feel that they can trust their social workers in order to be honest with them. The positive qualities that imbue "growth-promoting relationships" foster the type of relationships in which women with PSU can be honest about their use.

Mothers were clear about their need for MCFD social workers to have a better understanding of PSU. MCFD social workers' lack of knowledge about PSU was identified as a problem in terms of the following: worker credibility; enabling mothers to lie to social workers about their substance use; and social workers making inappropriate recommendations, based on a generalized response, rather than specific treatment needs of each woman. In assessing risk to children and developing RRSPs to address risk, it is essential that social workers have knowledge of PSU, and the various treatment options available in their community. At the very least social workers need to have knowledge of drug and alcohol counselling services that can complete treatment needs assessments and make appropriate recommendations such as referrals to treatment programs, if warranted, and in the absence of other available options.

Practice issues specific to Northern BC

For the two mothers from the smaller Northern BC community, their experiences varied drastically from the other mothers in that their children were returned to their care

very shortly after they were removed. Both of these mothers were also referred to counselling in their home community, as opposed to being mandated to go to a residential treatment program in another community. These mothers were also permitted to regain their role as primary caregiver to their children within a short period of time. The practice difference may have resulted from the relative geographic isolation from access to residential treatment programs; or the differences may reflect a leadership style that is less punitive and understands the value of keeping mothers in their parenting roles during their recoveries.

Another practice issue specifically related to Northern BC is the relatively large Aboriginal population and the overrepresentation of Aboriginal children in MCFD care. Some of the mothers spoke of their new found knowledge of the effects of Colonization as an important aspect of their healing. Certainly from a structural social work perspective, it is vital for MCFD social workers practicing in Northern BC to have an understanding of the effects of colonization on Aboriginal peoples. Social workers' awareness of the impact of residential schools, the multi-generational involvement with MCFD and perhaps most importantly their role in potentially perpetuating patriarchy will ideally illicit more empathetic and respectful practice.

Valuing relationship as important to the recovery process

Clearly, mothers emphasized the importance of their relationships with both social workers and drug and alcohol counsellors. The data show that it was typical for mothers to characterize their relationships with alcohol and drug counsellors as more positive and supportive than their relationships with their MCFD social workers. The more positive relationships with alcohol and drug counsellors are primarily due to their different roles and mandates.

The drug and alcohol counsellors who have had their own struggles with PSU and overcome it or are far along in their recoveries, seem to be held in highest regard by the mothers and also have the most positive influence on the women. The women in this study described how when they see counsellors who are also in recovery, it gives them hope for their own recoveries. Some positive attributes that the women identified in counsellors included: encouraging and positive, using humour in the therapeutic process, allowing for mistakes, being strict, and clearly communicating their expectations.

Limitations

As previously mentioned, I was unable to conduct member checking with the research participants to ensure that the categories identified most aptly reflected their experiences and thoughts on their experiences. The sample size is small and there is some homogeneity. Although generalizability is not an aim in qualitative research, one cannot extrapolate that the ten mothers in this study necessarily reflect populations of other mothers in the same situation in Northern BC. Additionally, I was only able to interview women from two communities in Northern BC, which does not provide the range of experiences that might be found in smaller and more remote communities with markedly differing resources and possibly MCFD social work and ADS practice approaches.

Discussion

My own values and ethics influence my desire to question power structures in the context of working with marginalized people. In particular, my own experience as a former child protection worker motivated me to go beyond questioning the inherent deficiencies within the system to look at what can be done to make it better. Child protection social workers are constantly attempting to balance the safety of children with their need to be with their parents. Finding this balance is typically a very difficult task.

Dichotomizing parent/child needs by removing children and mandating mothers to treatment has proven to be a relatively ineffective means of addressing PSU. Bishop (2002) argues that dichotomizing the needs of children and their mothers is in fact an oppressive practice and that children's well being is intimately tied to the well being of their mothers.

Mothers involved in the child welfare system in Northern BC are frequently marginalized by the circumstances of their lives and the poverty of opportunity to overcome those circumstances. This reality is exacerbated when they encounter the child welfare system. Further marginalization and oppression occurs on two levels: within the context of relationships with social workers; and also on a systemic level as a result of the current model of child welfare practice and the overlying managerial approach.

The mothers' subjective experience of judgment, negativity, coercion, and racism within the child welfare system perpetuates the oppression that these women have sometimes grown up with, and at times experienced in the dominant society. As discussed, the impact of this experience can have a negative affect on women's self-identity as competent mothers, who have serious problems that they need and want help to overcome. The voices of these mothers are strong, and they are committed women who love their children. They want and need social workers to view them in that light, and use their social work expertise, to provide the kind of support needed to manage their PSU through recovery, and in parenting their children. The mothers are explicit in their need for support, encouragement, empathy, and a positive approach to dealing with their PSU. Because the child welfare system's predominant mandate is typically the well being of

the child, and not the mother-child unit, women are often not provided with the support they need when it is most crucially needed (Tait, 2000)

The managerial approach to child welfare practice, implemented through the risk assessment model, serves to hold mothers in the child welfare system accountable for socio-economic realities that are clearly out of their control, such as a lack of safe, affordable housing. Implementing models of practice that are drawn from the business world, and using them to inform social work practice with marginalized people is akin to using a mallet to knead bread dough. The right tool makes any work easier, and the risk assessment model currently used by MCFD simply does not facilitate building strong relationships. Building strong, respectful relationships in the process of becoming an ally with the people one strives to help is fundamental to good social work practice. Social workers practicing in the current child welfare system face multiple challenges. Perhaps among the most difficult is the challenge of managing social work practice that reflects social work ethics and values within the context of a model that draws on managerialism and guided by significantly different ethics and values.

Implications for Policy and Practice

While there is an existing example of a training program developed specifically to address the relational problems in the child welfare system, this program is not being implemented at this time. Based on the emphasis that the mothers in this study placed on their expressed desire to have better relationships with social workers, implementing this type of program is a relatively cost effective approach to enhancing parent-social worker relationships.

A more costly, and much more involved, change to child welfare practice in this province would be to eliminate the use of the current risk assessment model.

Collaborative child welfare practice results in positive outcomes for families in other jurisdictions, such as the Every Child Matters initiative (Morrison, 2007). MCFD would do well to consider implementing a more collaborative approach that specifically addresses the overrepresentation of Aboriginal families involved in the child welfare system in BC.

The current adversarial approach to child protection in BC must change in order to improve outcomes for families affected by PSU. As revealed in Ayre's study (1998), despite significant efforts to make child protection social work more strength-based, it remains invariably blurred by a translucent overlay of negativity and a predominant focus on parental weaknesses.

Dissemination

Bound copies of this thesis will be sent to agencies who assisted with recruiting participants. Further attempts will be made to locate participants, who will also be offered a copy of the thesis. I will contact MCFD and offer to present the findings to MCFD social workers practicing in northern BC communities.

Areas for Future Research

Existing MCFD practice guidelines call for social workers to have knowledge of ADS, and take specific action to work collaboratively with ADS counsellors. Yet several mothers describe scenarios where they had little, or no, recollection of the workers from the two collaborating services. This apparent disconnect merits further investigation into the current practices in MCFD and ADS, to determine the prevalence of the lack of collaborative practice, and factors that contribute to the problem.

It is unclear from this research if the absence of appropriate referrals for ADS were due to lack of social workers understanding their responsibilities, or other possible

reasons, such as excessive workload demands getting in the way of a thorough and timely referral process. Research that involves interviews with social workers would provide further insight, and an alternate perspective on practice issues that hinder or facilitate more collaborative work between MCFD and ADS.

A focus on evidenced-based practice would consider implementation of the aforementioned training program aimed at improving social worker-parent relationships. Monitoring the implementation of the program and measuring its success could constitute a number of research projects.

Conclusion

The voices of the women in this thesis research leave no doubt about the challenges that they face daily. They describe a worsening of their PSU when their children were taken from their care. The mothers identified MCFD social workers as having a predominantly negative focus. This negativity may be informed by the shift to a managerial approach to child protection practice in BC. The risk assessment model used to guide child protection practice looks at parental and familial deficits, with little attention paid to parental or familial competencies, or cultural diversity. In particular, the risk assessment model does not acknowledge the historical impact of colonization on Aboriginal people in BC; and statistics show that this may in fact be a contributor to the disproportionate number of Aboriginal children in MCFD care. The mothers expressed frustration with their perception that MCFD social workers changed their expectations, leaving mothers unsure about what had to happen and when. The women talked about the negative impact their involvement with MCFD had on their self-image. Despite existing MCFD protocol for collaborative practice between MCFD and ADS, the mothers experienced only some collaborative work between the two services. The mothers were

clear about their practical and relational needs from MCFD social workers. The women identified their relationships with their ADS counsellors as important to their process of recovery from PSU.

There is a need to develop more respectful and collaborative social worker-parent relationships. Mothers identified that good working relationships with their social workers were integral to their progress in meeting MCFD expectations. There is also the challenge for MCFD child protection social workers to become allies with the families they serve, in the context of a system informed by the values and ethics of managerialism.

MCFD must work collaboratively with ADS to fund, develop, and follow through with interventions, and treatment programs that integrate substance abuse treatment and child protection services. Comprehensive, community-based, gender-based, substance abuse treatment programs, developed to address the many barriers to treatment for women, are long overdue. The importance of relationship as a means of facilitating MCFD involvement and women's recovery from PSU cannot be overstated. Of vital importance in planning and development of appropriate services, is the need to listen to the women who need and access these services. The voices of women are clear in their need for support in managing their PSU and parenting their children.

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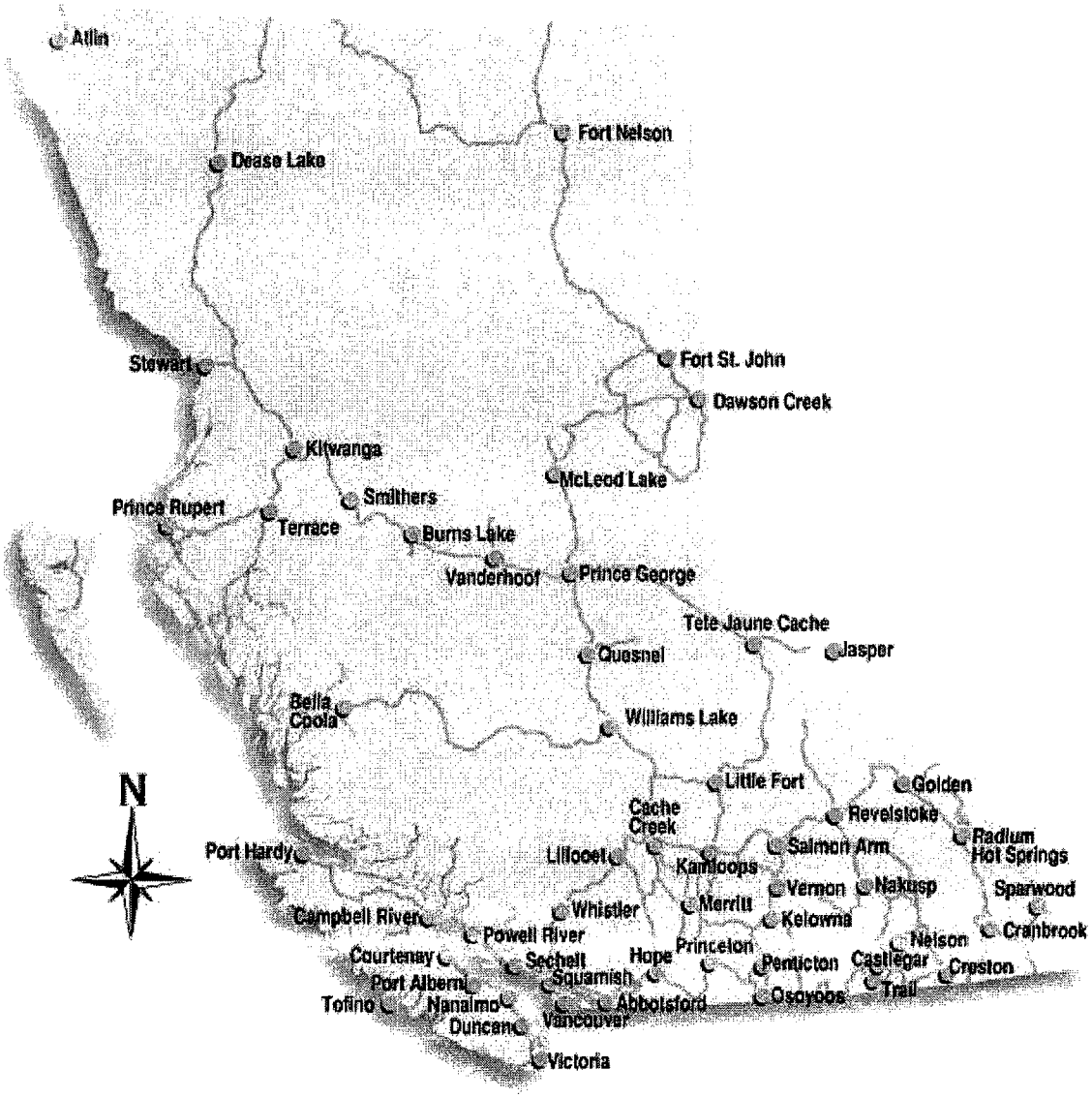
Appendix A



Map retrieved from: http://www.th.gov.bc.ca/popular-topics/distances/bcmap.html

Appendix B

Agency Letter of Introduction for Mothers

Carol Sanford, MSW Student, UNBC
3333 University Way, Prince George, B.C. V2N 4Z9
Cell phone: 250.612.8472 email: sanford@unbc.ca

Date
Name of Agency
Address, City, Postal Code

Dear _____,

As a graduate social work student at the University of Northern British Columbia I am required to conduct research and develop a thesis based on the findings. I would like you to consider granting permission for participants from your program to participate in this research.

The purpose of this research is to give voice to the experience of mothers in Northern BC who have had problematic substance use, and involvement with child welfare services. It is hoped that their stories, and insights will provide information about the process of meeting the requirements of child welfare services in British Columbia, namely the Ministry for Children and Family Development (MCFD), in order to maintain, or regain care of their children. Additionally mothers will be asked to share their process of engaging in treatment for problematic substance use. Mothers who agree to participate in this study are asked to share their own understanding of what would be helpful to them, and possibly other women, in their attempts to manage their problematic substance use and parent their children. All participation is completely voluntary and individuals are welcome to withdraw from the study at any time.

I request that if you agree to your agency participating in this research, please send a letter of consent from your organization. This letter is required for the approval of the UNBC Research Ethics Board, and must be received by me prior to commencing this research. Once I have received your letter of consent I will either deliver, or mail posters to you to display where they will be visible to program participants. The posters will explain the research project, and request that mothers who are interested in participating contact me at the cell number on the poster to arrange for a face-to-face interview.

All participants can choose, or will be assigned fictitious names to protect their identities, and maintain confidentiality. The participant information sheet has been included with this letter for you and your staff to look over before making a decision. If you have any additional questions or concerns, please feel free to contact me via phone or email. For those agencies located outside of Prince George, please feel free to phone me collect.

I will be contacting your agency by phone within the next two weeks to follow up. Your support is sincerely appreciated,

Carol Sanford, MSW Student, UNBC

Appendix C

Project Information Sheet for Mothers

Graduate Student Thesis Researcher: Carol Sanford, Masters of Social Work Student
c/o University of Northern BC School of Social Work,
3333 University Ave., Prince George, B.C. V2N 4Z9
Email: sanford@unbc.ca Cell phone number.: 250.612.8472

Thesis Title: Mothers, problematic substance use, and the child welfare system in Northern British Columbia.

Supervisor: Dr. Glen Schmidt, Associate Professor, School of Social Work, UNBC

Purpose of research:

The purpose of this research is to give voice to the experience of mothers in Northern BC who have had problematic substance use, and involvement with child welfare services. It is hoped that by you sharing your experiences, and insights you will provide information about trying to meet the requirements of child welfare services in British Columbia, namely the Ministry for Children and Family Development (MCFD), in order to maintain, or regain care of your children. Additionally mothers will be asked to share their experience of the process of engaging in treatment for problematic substance use.

Mothers who agree to participate in this study are asked to share their own understanding of what would be helpful to them, and possibly other women, in trying to meet the expectations of MCFD and treatment programs.

Respondents will be asked to:

- contact the researcher at the cell number above to arrange a time and place for an interview, or let the agency contact person know you interested in participating and ask that the researcher be contacted on your behalf;
- commit about one and a half hours of time for the interview process;
- answer the researchers demographic questions, and questions about your experience of being a parent and living with problematic substance use, and your experience with MCFD and treatment services;
- give consent (in writing) to be interviewed, and have the interview recorded by hand and on a digital voice recorder,
- allow the researcher to use quotes and demographic information from your interview that do not identify you personally;
- agree to speak to the researcher (either in person or by phone) for a half hour follow-up interview if possible.

Potential benefits and risks to participants:
Risks

There may be some risk to participants of this study. These risks could include concerns about confidentiality regarding both the location of the interview, and their personal information. Also participants could become emotionally upset because of the subject matter in question. An additional risk is that participants may disclose information about a child who has been neglected or harmed, which would necessitate a report to MCFD.

To address the risk of confidentiality with respect to the location of the interview, they will only take place in a setting where participants feel comfortable. Participants may also be concerned about what will happen with their information.

- interviews will be manually and digitally recorded with permission of the participants;
- only the researcher and her supervisory committee of three UNBC professors (who are all obliged to respect your confidentiality) will have access to the information provided in the interviews;
- the written and digital recordings of the interviews will be kept in a locked filing cabinet in this researcher's home office, and the voice recordings will be transcribed into computer files. The researcher may use the services of a transcriber, who will also be obliged to respect your confidentiality). The computer files will be protected by password and firewalls. Since the participants will only be consenting to the use of their information for the purpose of this thesis research, and any subsequent presentations, or publications, the computer files and transcripts will be shredded and/or deleted after this student researcher has successfully defended the proposed thesis;
- any potentially identifying information will be removed or altered when input into the computer, participants will be encouraged to identify a Pseudonym to protect their identity, or a pseudonym will be chosen on their behalf;
- there will be efforts made to eliminate any identifying information included in the final study findings, however personal experiences shared may be familiar to people you know;
- the final study will be published as a thesis and possibly published in relevant journals, or presented at conferences.

The risk of a participant becoming emotionally upset will be addressed as follows:

- participants can decline to answer any questions that they choose not to answer, can decline to continue with the interview, can ask that any information they provide be removed from the study;
- at any time that a participant is emotionally distressed she will be provided with a referral to appropriate services that can provide counselling or support;

The risk of a participant disclosing information about a child who may have been neglected or harmed will be addressed as follows:

- at the beginning of each interview the researcher will identify that she is able to maintain confidentiality of the information shared, with the exception of information that may indicate a child has been neglected or harmed. The researcher will explain that she is has a legal duty to report this information to MCFD.

Benefits

There are a many benefits to participating in this study. Participants will have the opportunity to think about their experiences, and consider what worked for them and what did not. This may provide participants with a better understanding of their own needs in relation to these experiences, and help them to express those needs. Participants will have the opportunity to 'give voice' to women who are working hard to manage their problematic substance use and parent their children. Participants will help this, and other researchers, have a better understanding of the process of involvement with these service systems in Northern BC. Researchers can use this knowledge to recommend changes to the service providers whose responsibility it is to help and support these mothers.

Participants can request and receive a copy of the study from this researcher when it is completed. Participants receive a $30.00 honorarium for agreeing to participate in this study. Should participants require any additional information at any time before, during, or after the study they can contact the student researcher Carol Sanford by email at sanford@unbc.ca or cell phone at 250.612.8472, or my thesis supervisor, Dr. Glen Schmidt by email at Schmidt@unbc.ca or phone at 250.960.6519. Participants can withdraw from the research at any time, and their information will automatically be withdrawn and destroyed by shredding documents and deleting relevant files. Any complaints about the research project should be made to the Office of Research, University of Northern British Columbia 250.960.5610, or by email: reb@unbc.ca

Appendix D

UNBC Graduate student is looking for mothers in Northern BC who are willing to be interviewed. September – December 2008

This graduate student research is about the experience of mothers who have had problems related to drugs (prescription and non-prescription) or alcohol. Participants must also have been involved with the Ministry of Children and Family Development (MCFD), now or in the past.

The researcher is interested in talking to mothers about their experiences of working with MCFD social workers, addictions counsellors, and treatment programs.

What do you have to do?
Let your agency worker know that you are interested in participating in this researcher and ask her/him to forward you name to the researcher. Or, c.ontact the student researcher either by the email address below, or a **collect** call to the cell phone number below to arrange an interview.

How much time will it take?
Each interview will take about an hour to an hour and half. Follow up contact with researcher will take about half an hour to forty-five minutes.

Where can the interview happen?
The interview can take place at any safe location in your home community.

A $30.00 honorarium will be provided for mothers who agree to participate in this research.

Information shared for the purpose of this study will be kept confidential.

Call Carol at cell number: 250.612.8472
email address: **sanford@unbc.ca**

Appendix E

Participant mothers' demographic interview questions

Please answer these questions to the best of your ability. If you choose not to answer a question please indicate that you want to pass on this question and move on to the next.

1) What is your age?
   - ☐ 19-28 yrs
   - ☐ 29-38 yrs
   - ☐ 39-48 yrs
   - ☐ 49-58 yrs
   - ☐ 59-68 yrs

2) What level of education have you completed?
   - ☐ Elementary school
   - ☐ Middle school/Junior High school
   - ☐ Some High School
   - ☐ Graduated Grade 12
   - ☐ Some College or University
   - ☐ Graduated College or University
   - ☐ Other _____ (please specify)

3) What is your sexual orientation?
   - ☐ bisexual
   - ☐ lesbian
   - ☐ heterosexual
   - ☐ Other _____ (please specify)

4) Do you have a disability?
   - ☐ no
   - ☐ yes If yes, what is the nature of the disability?

   _____(please specify)

5) What is your relationship status?
   - ☐ Single
   - ☐ Dating
   - ☐ Living Common-Law
   - ☐ Married
   - ☐ Divorced
   - ☐ Widowed
   - ☐ Other _____ (please specify)

6) How many children do you have?
   - ☐ One
   - ☐ Five

☐ Two
☐ Three
☐ Four
☐ Six
☐ Seven
☐ Eight or more

7) What are the ages of each child?

☐ _____ ☐ _____
☐ _____ ☐ _____
☐ _____ ☐ _____
☐ _____ ☐ _____

8) How many of your children are under the age of 19 are currently living with you?

☐ One
☐ Two
☐ Three
☐ Four
☐ Five
☐ Six
☐ Seven
☐ Eight or more

9) If your children are not currently living with you, where are they living?

☐ With another family member
☐ With a family friend
☐ In an Ministry for Children and Family Development approved Kith and Kin home
☐ In foster care
☐ Other: _____ (please specify)

10) What is your ethnicity?

☐ First Nations
☐ Metis
☐ Inuit
☐ Asian
☐ White/Caucasian
(please choose more than one if necessary)
☐ Other: _____ (please specify)

11) What is your annual household income?

☐ less than $15,000
☐ $15,000 - $24, 999
☐ $25,000 - $39,999
☐ $40,000 - $59,999
☐ $60,000 or more

12) Are you currently employed?

☐ Yes
☐ No

13) If you are currently employed, what is your employment status?

- ☐ Full-time
- ☐ Part-time
- ☐ Casual
- ☐ On call
- ☐ Other _____ (please specify)

14) What is your postal code? _____

15) If you do not have a postal code, please describe your current living arrangement.

_____

_____

_____

_____

Appendix F

Mothers' Informed Consent Form

I understand that I am agreeing to participate in a research study.	□ Yes	□ No
I have myself read, or the researcher has read the attached information sheet to me and I have received a copy.	□ Yes	□ No
I understand that the researcher will record some information by hand on a form, and that the interviews will be voice recorded and some hand written may be taken as well.	□ Yes	□ No
I understand the benefits and risks involved in participating in this study.	□ Yes	□ No
I have had the opportunity to ask questions and discuss the study with the researcher.	□ Yes	□ No
I understand that my participation in this study is voluntary and I can withdraw from the study at any time. ***I do not have to give a reason and it will not affect the honorarium.***	□ Yes	□ No
I understand that the researcher is obliged to maintain my confidentiality, and that no personally identifying information will be used in the final thesis report.	□ Yes	□ No
I understand that only the student and her supervisory committee (consisting of three UNBC professors) will have access to identifying information about me.	□ Yes	□ No
I understand that if I disclose information about a concern for the safety of a child that the research is has a legal duty to report that information to a child protection social worker.	□ Yes	□ No

This study was explained to me by: Carol Sanford, Master of Social Work Student
I agree to take part in this study: Date: _____

_____ _____
Signature of Research Participant *Printed Name of Research Participant*

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ Date: _____Signature of Researcher

Appendix G

Participant Mothers' Interview Guide

1. What was your process for being referred to treatment and working to meet the expectations of MCFD?
2. If you attended some form of treatment for problematic substance use, what was helpful to you about that experience?
3. Do you know if your social worker and treatment staff were working together to try to help you?
4. What recommendations do you have to make the experience of being involved with child welfare an easier experience for mothers?
5. What recommendations do you have to make the experience of treatment for problematic substance use better for mothers?

- Involvement, with respect to MCFD is defined in this study as having been under investigation for a child protection matter as defined by the British Columbia Child and Family Community Service Act. Involvement with respect to treatment for problematic substance use, in this study is defined as having been referred by MCFD, or court ordered to treatment and engaged in the service for the duration of the program.

Appendix H

Key Informants Interview Guide

1. In considering the following concepts provided by mothers who were interviewed for this research, are there any that are surprising to you?
2. Are there any that particularly stand out as unusual, or novel?
3. Are there any that you have heard before in your work with mothers who have problematic substance use?

Appendix I

Agency letter of introduction for Key Informants

Carol Sanford
C/O Dr. Glen Schmidt, UNBC
3333 University Way
Prince George, B.C. V2N 4Z9
(2 :.ca

Date

Name of Agency
Address
City
Postal Code

Dear _____,

As a graduate social work student at the University of Northern British Columbia I am required to conduct research and develop a thesis based on the findings. I would like you to consider granting permission for workers from your treatment program to participate in this research.

The purpose of this research is to give voice to the experience of mothers in Northern BC who have had problematic substance use, and involvement with child welfare services and treatment programs for substance misuse. It is hoped that their stories, and insights will provide information about the process of meeting the requirements of child welfare services in British Columbia, namely the Ministry for Children and Family Development (MCFD), in order to maintain, or regain care of their children. Additionally mothers will be asked to share their process of engaging in treatment for problematic substance use. Mothers who agree to participate in this study are asked to share their own understanding of what would be helpful to them, and possibly other women, in trying to meet the expectations of MCFD and treatment programs.

I would also like to interview treatment program workers who have worked with these women to get their perspective of the process that these women must go through, and on what they think is needed to better serve them. All participation is completely voluntary and individuals are welcome to withdraw from the study at any time.

I request that if you consent to staff participating in this research, please share this letter with your staff and encourage any interested staff members to contact me. If your program does consent to participate in this research, I ask that you please send me a letter of consent from your organization. This letter is required for the approval of the UNBC Research Ethics Board, and must be received prior to me commencing research.

Please request that any interested staff member can contact me at my cell number, or email address below.

Once staff contact me, and I have the Research Ethics Board approval to proceed, arrangements can be made for a face-to-face interview. All participants can choose, or will be assigned fictitious names to protect their identities and confidentiality will be maintained. The participant information sheet has been included with this letter for you and your staff to look over before making a decision. If you have any additional questions or concerns, please feel free to contact me via phone or email. For those agencies located outside of Prince George, please feel free to phone me collect.

Your support is sincerely appreciated,

Carol Sanford, MSW Student, UNBC

Appendix J

Key Informant
Project Information Sheet

Graduate Student Thesis Researcher: Carol Sanford, Masters of Social Work Student
c/o University of Northern BC School of Social Work,
3333 University Ave., Prince George, B.C. V2N 4Z9
Cell phone number.:

Thesis Title: Mothers, problematic substance use and the child welfare system in Northern British Columbia.

Supervisor: Dr. Glen Schmidt, Associate Professor, School of Social Work, UNBC

Purpose of research:
The purpose of this research is to give voice to the experience of mothers in Northern BC who have had problematic substance use, and involvement with child welfare services. It is hoped that their stories, and insights will provide information about the process of meeting the requirements of child welfare services in British Columbia, namely the Ministry for Children and Family Development (MCFD), in order to maintain, or regain care of their children. Additionally mothers will be asked to share their experience of the process of engaging in treatment for problematic substance use. Mothers who agree to participate in this study are asked to share their own understanding of what would be helpful to them, and possibly other women, in trying to meet the expectations of MCFD and treatment programs.

As a key informant you will be asked to:

- contact the researcher at the cell number above to arrange a time and place for an interview;
- commit about one and a half hours of time for the interview process;
- answer the researchers demographic questions, and questions about your experience of working with mothers who have problematic substance use, and your experience with working with MCFD;
- give consent (in writing) to be interviewed, and have the interview recorded by hand and on a digital voice recorder,
- allow the researcher to use quotes and demographic information from your interview that do not identify you personally;

Potential benefits and risks to participants:

Risks

There may be some risk to participants of this study. These risks could include concerns about confidentiality regarding both the location of the interview, and their

personal information. An additional risk is that participants could become emotionally upset because of the subject matter in question.

To address the risk of confidentiality with respect to the location of the interview, they will only be scheduled to take place in settings where key informants feel comfortable. This can be in their place of work, homes, or another community location as identified by the participant. If necessary these interviews can take place by phone.

Participants may also be concerned about what will happen with their information.

- interviews will be digitally recorded and some manual notes will be taken as well with participants' permission;
- only the researcher and her supervisory committee of three UNBC professors (who are all obliged to respect your confidentiality) will have access to the information provided in the interviews;
- the written and digital recordings of the interviews will be kept in a locked filing cabinet in this researcher's home office, and the voice recordings will be transcribed into computer files. The computer files will be protected by password and firewalls. The computer files and transcripts will be destroyed after this student researcher has successfully defended the proposed thesis;
- any potentially identifying information will be removed or altered when input into the computer, key informants will be encouraged to identify a pseudonym to protect their identity, or the researcher will assign one for them;
- there will be no identifying information included in the final study findings, however personal experiences shared may be familiar to people you know;
- the final study will be published as a thesis and possibly published in relevant journals, or presented at conferences. No information that could identify participants will be included in the final study, or subsequent publications or presentations;

This risk of a key informant becoming emotionally upset will be addressed as follows:

- key informants can decline to answer any questions that they choose not to answer, can decline to continue with the interview, can ask that any information they provide be removed from the study;
- at any time that a key informant is emotionally distressed she will be referred to appropriate services that can provide any necessary counselling or support;

Benefits

There are a many benefits to participating in this study. Key informants will have the opportunity to think about their experiences, and consider what they think worked for the mothers in their programs, and what did not. This may provide key informants with a better understanding of these mother's needs, and help them to express those needs and implement program changes. Additionally key informants will have the opportunity to reflect on their own practices.

Key informants will help this researcher have a better understanding of the process of involvement with these service systems in Northern BC. Researchers can use this knowledge to recommend changes to the service providers, and policy makers, whose responsibility it is to help and support these mothers.

Key informants can request and receive a copy of the study when it is completed. Should participants require any additional information at any time before, during, or after the study they can contact the student researcher Carol Sanford by email at sanford@unbc.ca or cell phone at ., or my thesis supervisor, Dr. Glen Schmidt by email at Schmidt@unbc.ca or phone at Any complaints about the research project should be made to the Office of Research, University of Northern British Columbia 250.960.5610, or by email: reb@unbc.ca.

Appendix K

Key Informant - Informed Consent Form

I understand that I am agreeing to participate in a research study.	□ Yes	□ No
The researcher has read the attached information sheet to me and I have received a copy.	□ Yes	□ No
I understand that the researcher will record some information by hand, and that the interviews will be voice recorded as well.	□ Yes	□ No
I understand the benefits and risks involved in participating in this study.	□ Yes	□ No
I have had the opportunity to ask questions and discuss the study with the researcher.	□ Yes	□ No
I understand that my participation in this study is voluntary and I can withdraw from the study at any time. ***I do not have to give a reason and it will not affect the honorarium.***	□ Yes	□ No
I understand that the researcher is obliged to maintain my confidentiality, and that no personally identifying information will be used in the final thesis report.	□ Yes	□ No
I understand that only the student and her supervisory committee (consisting of three UNBC professors) will have access to identifying information about me.	□ Yes	□ No
I understand that if I disclose information about a concern for the safety of a child, the research has a legal duty to report that information to a child protection social worker.	□ Yes	□ No

This study was explained to me by: Carol Sanford, Master of Social Work Student
I agree to take part in this study: Date: _____

_____ _____
Signature of Research Participant *Printed Name of Research Participant*

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ Date: _____
Signature of Researcher

Appendix L

TRANSCRIBER OATH OF CONFIDENTIALITY

As the transcriptionist hired to transcribe interviews for the research project, *Mothers, Problematic Substance Use and Child Welfare in Northern BC,* I will treat as confidential all information learned through transcribing the interviews of research participants.

To help ensure the safety and confidentiality of data, transcriptions will be password protected. I will not print any hard copies. When transcriptions are complete, I will electronically send them to the researcher, using a secure method. I will delete the file from my hard drive once the researcher indicates that the file has been successfully received.

I further understand and agree that this Oath of Confidentiality will continue in force indefinitely, even after I cease being an employee on this project.

Name of transcriptionist: (print) _____

(signature)) _____

Date:) _____

Researcher's name: (print) _____

(signature) _____

Date: _____

Project Contact Information:
Carol Sanford, UNBC, *ell*
Dr. Glen Schmidt, UNBC,

Note: A copy of this Oath of Confidentiality will be given to the transcriber.

Appendix M

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

RESEARCH ETHICS BOARD

MEMORANDUM

To: Carol Sanford
CC: Glen Schmidt

From: Greg Halseth, Acting Chair
Research Ethics Board

Date: September 29, 2008

Re: **E2008.0812.145**
Mothers, problematic substance use, and the child welfare system in Northern BC

Thank you for submitting the above-noted proposal to the Research Ethics Board. Some changes and clarification have been requested;

- Provide the committee with clarification on the honorarium
- Clarify for the committee if agencies will be giving consent to advertise for participants (put up posters)
- Clarify if this research is NHA funded
- On the information sheet;
    - Create a simpler, shorter consent form
    - Ensure that when a participant withdraws that their information will automatically be withdrawn (not if request it specifically)
    - Clarify what will happen with the data, who will have access, when it will be destroyed and how
    - Create a tick box for consent – this is clearer for the participant

Please provide a copy of your proposal with these modifications to Debbie Krebs in the Office of Research and a letter of approval will be forwarded.

Sincerely,

Greg Halseth