EXPERIENCES OF INDIGENOUS MOTHERS WITH THE CHILD WELFARE SYSTEM AT THE BIRTH OF THEIR CHILD

by

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Abstract

The topic of Indigenous women's experiences with the Ministry of Children and Family Development (MCFD) at the birth of their child is one that falls through the gaps of current literature. This thesis is focused on identifying the experiences of Indigenous women when MCFD intervenes at the birth of their child; the purpose is to gain insight into the strengths and weaknesses of child welfare interventions. I interviewed five Indigenous women using an interpretive description approach and analyzed the data using constant comparative analysis as well as conventional content analysis techniques. The findings highlighted the impact of child welfare involvement that included: powerful emotions, trust, communication and dismantled families; a structural power imbalance characterized as feeling powerless, being watched and judged, and jumping through hoops; addiction; socioeconomic struggles that included young mothers and homelessness, poverty, and neglect; missed preventative opportunities; the role of advocacy; identity and culture; and bonding. In conclusion, child welfare practice needs to include opportunities for preventative measures and planning to optimize support and communication with Indigenous pregnant women and mothers.

Keywords: Indigenous; at birth; MCFD; intervention

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Dedication

I dedicate this thesis to the strong, beautiful, unstoppable Indigenous women and mothers who inspire me every day to be a better social worker and to support the fight for a better future. The strength and determination of these women have helped shape my social work practice and encouraged me to create this thesis.

Chapter 1: Introduction

It is not uncommon for an Indigenous woman to give birth to her infant and have a child protection social worker from the Ministry of Children and Family Development (MCFD) arrive at the hospital to assess her parental capacity and determine the level of safety risk to the newborn. The social worker may arrive anywhere from a few hours to a few days after the birth, depending on the nature and assessment of the child protection report. The outcome of this visit may result in the removal of the baby or the implementation of an immediate, short-term safety plan that ensures the baby's safety. Depending on the outcome of the visit, the baby may remain with the mother and/or the father, the child may be placed with a family member or person identified by the family that MCFD must approve, or the child may be placed in a foster home. A visit from a child welfare social worker can be emotional and possibly traumatic for the infant and his or her mother. It has been my experience that a collaborative approach between the family, the child protection social worker, and other support agencies prior to the birth of a child can improve the outcome for the mother and infant. This chapter includes my personal experience and disciplinary knowledge in the professional discipline of social work, which allows for an applied methodological approach within an inter-professional setting. In addition, it discusses the purpose of my research, the significance of the study, and the guidance of social work epistemology and its limitations; it delineates the research questions; and it provides definitions of terms and an outline of the chapters that follow.

Informing this Research

Positioning the researcher is important because it allows the reader to learn about the researcher's beliefs, values, biases, and experiences in the field (Thorne, 2016). It is essential to understand what inspired the researcher to pursue his or her topic and what the expectations of the results might be. My first experience working with Indigenous women was during the fourth year practicum of my Bachelor of Social Work degree at the University of Northern British Columbia (UNBC). The practicum placement was at Vancouver Aboriginal Child and Family Services Society (VACFSS). I gained knowledge about the Child, Family and Community Service Act (CFCSA) and witnessed social workers empower Indigenous women and implement successful approaches during this practicum placement. Every pregnant woman accessing services was provided a doula to support her during and after her pregnancy. Neel, Goldman, Marte, Bello, and Nothnagle (2019) described a doula as a trained healthcare professional who offers information and emotional and physical support, before, during, and after pregnancy; doula is also defined under the definitions of terms section. The experience of providing doulas to support pregnant Indigenous women has stuck with me, as it highlighted positive social work practice and demonstrated that the child welfare system can implement creative and preventative measures. This three-month practicum at VACFSS was a powerful learning experience—the team focused on prevention by putting services in place before the birth of a child and by developing and implementing a safety plan subsequent to the birth.

I was employed with MCFD in 2011 for one year and I did not observe the same level of prevention and support for Indigenous women at MCFD as was provided by the social workers at VACFSS. I acquired employment at Nezul Be Hunuyeh Child and Family

Services Society (NBHCFSS) in 2014, where I have witnessed the difficulties experienced by Indigenous mothers who encounter the child welfare system. I reflect on my experiences from VACFSS frequently and allow it to guide my current social work practice. These experiences constantly remind me to focus my professional practice on prevention and support when providing services to Indigenous children and families. In addition, I have the opportunity to work alongside MCFD social workers in my role at NBHCFSS. I have unfortunately witnessed a lack of cultural awareness, preventative practice, and limited supports provided to Indigenous families. I often push back against the system in order to advocate for the women, men, children, and families I work with, often with no results. I feel the system is flawed on multiple levels and my positive and negative experiences with the child welfare system have driven me to conduct research on how to support Indigenous women and mothers. I specifically focus on preventative opportunities which improve outcomes for Indigenous children and mothers involved with the child welfare system at the birth of their child.

Research Significance

During my professional career, I have witnessed the fear and despair of women who are at risk of losing their child at birth or have lost their child shortly after birth. The trauma for both mother and child can be heartbreaking. I hope that the knowledge generated from this research provides preventative strategies to protect the bond and relationship between a mother and her child.

Shahram et al. (2017) depicted a mother's narrative that delves into the emotions of the child welfare system:

> [Mothers] need to build that bond with their babies. If the Ministry could just let the parent be with their baby and build that bond, nothing will ever break that bond. They'll do anything for their kid to the point where staying clean and sober to be able to keep their baby. And when you don't have that bond, that kid's basically someone else's kid. . . . It's that bond that needs to be built in order for a parent to succeed in mothering and parenting their children. [Let us] parent our children and give us that chance and not just use everything that we have been through and done against us. Because once you have a baby in your life and you actually get to parent and love somebody, it's just a whole new world. It's a whole new you. And you would do anything to keep them. (p. 255)

This quotation truly resonates with me because it is devastating to arrive at the hospital and watch a child being removed from his or her mother's care. It is essential to ensure children are physically safe, and in doing so, it is important to examine the emotional and spiritual impact certain child welfare interventions have on mothers and infants. Child protection interventions serve a purpose and are sometimes warranted but it is essential to examine the importance of bonding and the effect on a child who has been denied the crucial bond and relationship with their mother.

Indigenous women encounter additional barriers directly related to colonization such as intergenerational trauma, residential schools, the Sixties Scoop phenomenon, and socioeconomic struggles (Aguiar & Halseth, 2015; Bennett, 2008, 2009; Carriere & Richardson, 2009; Chen et al., 2015; Cull, 2006; Evans-Campbell, 2008; Ing, 2006; Johnston, 1983; McKenzie, Varcoe, Brown, & Day, 2016; Niccols, Dell, & Clarke, 2009; Rousseau, 2015; Shahram et al., 2017), that are presented in the literature review. Research

also revealed that between 70% and 80% of children in care of the British Columbia government are of Indigenous descent (Ministry of Children and Family Development, 2010; McKenzie et al., 2016; O'Donnell et al., 2010; Rousseau, 2015, 2018; Trocme, Knoke, & Blackstock, 2004).

Indigenous women often turn to alcohol and drugs to numb their pain because of the aforementioned barriers (Bennett 2008, 2009; Evans-Campbell, 2008; Taplin & Mattick, 2015). Substance abuse interventions consequently often play a large part in the child welfare system in order to mitigate the risk to the child (Bennett, 2008; Crowe-Salazar, 2012; Perry, Newman, Hunter, & Dunlop, 2015; Reid, Greaves, & Poole, 2008; Taplin & Mattick, 2015). These substance abuse interventions can often lead to a disruption of the bond between mother and child due to a child protection intervention or removal (Bennett, 2008; Shahram et al., 2017). The bonding between a mother and her child is essential for healthy development, mental and physical health for both mother and child, and a connection which builds the unbreakable bond between mother and child (Greaves & Poole, 2004; Newman et al., 2015; Reid et al., 2008; Shahram et al., 2017).

The anticipation of your child being removed at birth or the thought of a child welfare social worker attending the hospital to implement a safety plan can discourage mothers from accessing prenatal care and informing supportive agencies of their pregnancy. These mothers may not seek help for addictions or address domestic violence issues to hide their pregnancy (Bennett, 2008, 2009; Rousseau, 2015; Varcoe, Brown, Calam, Harvey, & Tallio, 2013).

Purpose of the Research

The goal of my research was to examine and explore the experiences of Indigenous mothers involved with the child welfare system at the delivery of their baby for the purpose

of informing practice and future research, all intended to improve outcomes for Indigenous children and families. My research focused on the experiences of Indigenous women who had involvement with the Ministry of Children and Family Development (MCFD) at the birth of their baby in the area of Prince George, BC. Five Indigenous women shared their stories regarding the barriers and strengths that they encountered in relation to the child protection processes. A secondary goal of the research findings is to shed light on the impact child welfare interventions can have on Indigenous women and children, and possibly lead to improved outcomes for Indigenous women and children. Women who had experienced a visit by a child protection social worker at the birth of their baby can be a rich source of knowledge that has the potential to spark change within the child welfare system and to help professionals support expecting Indigenous women.

Research Question and Objectives

My research question was, what are the experiences of Indigenous mothers who had involvement with the Ministry of Children and Family Development at the birth of their newborn?

The main objectives of this research thesis were:

- to provide Indigenous mothers with a chance to voice their experiences relating to MCFD involvement at the birth of their child;
- to understand the barriers and strengths Indigenous mothers face in relation to the child welfare process;
- to identify what Indigenous mothers believe could be done differently so MCFD does not show up at the birth of a child; and
- to understand the role bonding plays in creating change for Indigenous mothers.

Disciplinary Framework—Theoretical Location

The conventional qualitative approaches to inquiry (phenomenology, grounded theory, narrative, ethnography, case study) dictate that a study must be firmly positioned within a theoretical framework (Thorne, 2014). It is common for nursing scholars to subscribe to one of the aforementioned qualitative approaches despite concerns related to the theoretical constraints associated with the specified methodological choice (Morse, 1989; Thorne, 2008). Thorne, Stephens, and Truant (2016) claimed that the adherence to an external theoretical framework compromised the logical integrity of a nursing enterprise, as the findings generated had minimal impact on the application to practice. Interpretive Description (ID) was conceived and recognized as an applied qualitative methodology derived from nursing epistemology that borrows the best technique from conventional social science methods in the absence of the external theoretical constraint (Thorne, 2013). Thorne et al. (2016) argued that the "intellectual underpinnings of an applied discipline can provide an effective framework where qualitative technique can be aligned" (p. 452). ID illustrates the subjective experiences of individuals to explore issues or patterns that affect a larger population (Bertero, 2015; Brewer, Harwood, McCann, Crengle, & Worrall, 2014; Hunt, 2009; Thorne, 2016). Hunt (2009), Thorne (2014, 2016), and Thorne et al. (2015) presented ID as a method grounded in a discipline's theories, systems, values, and beliefs, resulting in a yielding of knowledge which can guide practice. Theory is defined by Thompson (2018) as "an underlying professional knowledge base" (p. 9). It is important to understand the theory of the discipline being explored when using ID as a research method, in this case social work, as a basis on which to begin building knowledge (Hunt, 2009; Thorne, 2014, 2016; Thorne et al., 2015). Social work theory determines that "we are all unique individuals in a social

context. And, to do justice to the complexity of human experience, we need to take account of both the uniqueness and the social context, with its influences and constraints" (Thompson, 2018, p. 18).

I chose my research topic because my professional practice with Indigenous women illustrated real-life struggles that Indigenous mothers face, in addition to gaps in both the literature and applied practice. My professional discipline in social work, coupled with my professional experience, has fuelled my interest to explore this problem. I have witnessed child welfare social workers intervene with Indigenous women at the birth of their baby. I was able to gather information from Indigenous mothers regarding their experiences with MCFD at the birth of their child.

Definition of Terms

At Birth – For the purposes of this thesis *at birth* encompasses the time during which a newborn infant is in the hospital. This timeframe can vary from a few hours to a few months, depending on the family and situation. Wall-Wieler, Roos, Brownell, Nickel, and Chateau (2018) used the term *at birth* to include all children who had a child welfare file opened within seven days after birth. Figueiredo, Costa, Pacheco, and Pais (2009) also used the term *at birth* to examine bonding between a mother and her infant.

Bond(ing) – The first relationship between a parent or primary caregiver and an infant that affects the infant's emotional and psychological well-being as they grow and can affect their ability to build trusting relationships as adults (O'Connor, 2018).

Child, Family and Community Service Act (CFCSA) – The CFCSA is the governing legislation for delegated social workers in British Columbia (Government of British Columbia, n.d.). The CFCSA legislation defines when a child is in need of protection and

gives authority to social workers to intervene (Representative of Children and Youth, 2015). Child protection services are aimed to protect children from harm. Where there is reason to believe a child has been abused or neglected, child protection social workers have the delegated authority to investigate and take appropriate action to ensure that child's safety.

Delegated Aboriginal Agency (DAA) – According to a report from the Representative of Children and Youth (RCY) (2017), DAAs are agencies which have received delegation from the minister under section 91 of the CFCSA and work with Indigenous children and families, in and out of the community. In BC, there are 23 DAAs, which care for 42% of Indigenous children in care (RCY, 2017).

Director – A person designated by the minister to complete duties as per section 91 of the CFCSA (Government of British Columbia, n.d.). This means that the director of child welfare gives his or her authority to social workers to be able to enact the CFCSA.

Doula – Neel et al., (2019) describe a doula as a trained health worker who "provides continuous informational, physical, and emotional support during pregnancy, labor, and immediately postpartum" (p. 355). The involvement of a doula can have numerous positive outcomes including, higher breastfeeding rates and more satisfying birth experiences (Neel et al., 2019).

Indigenous – While the term Aboriginal is widely used in Canada to encompass First Nation, Inuit and Métis peoples, it has often been associated with colonialism and is used less often. Indigenous is a more globally accepted term to encompass First Nation, Inuit, and Métis peoples and is the term used in Indigenous rights movements (Kurtz et al., 2018).

Intervention – Any action taken by MCFD or other delegated authority which requires a safety plan, Supervision Order, or removal of the child or children due to safety concerns under section 13 of the CFCSA (Government of British Columbia, n.d.).

Ministry of Children and Family Development (MCFD) – "In B.C., MCFD is responsible for the administration and delivery of child welfare services, including child protection" (RCY, 2015, p. 14). MCFD works with Delegated Aboriginal Agencies, Indigenous service partners, and approximately 5,400 contracted community social service agencies and foster homes, as well as cross-government and social sector partners to deliver inclusive, culturally respectful, responsive, and accessible services that support the well-being of children, youth, and families (Ministry of Children and Family Development, n.d.).

Northern British Columbia – For the purposes of this thesis, the definition of Northern British Columbia (BC) will follow the government's district map (Government of British Columbia, Ministry of Transportation, n.d.). This map includes Prince George and all areas geographically north, east, and west of Prince George to be considered northern BC.

Removal – Under the CFCSA, a removal under section 30, 36, or 42 enables a delegated social worker to take custody of a child or children from their parent(s) for safety reasons (Government of British Columbia, n.d.).

Summary

My professional experience as a social worker working with Indigenous children, mothers and families has led me to explore the experiences of Indigenous mothers with the child welfare system (MCFD) at the birth of their child. I was able to interview five Indigenous women who had involvement with MCFD when their child or children were born by using an interpretive description approach that is rooted in social work. My professional

wisdom and passion for keeping mothers and babies together at birth, coupled with the wealth of literature regarding the impact of historical practices on Indigenous families such as the Sixties Scoop, residential school, intergenerational trauma, and colonization, has resulted in the development of this thesis. The next chapter explores both the well-established literature concerning Indigenous peoples and the gaps in the literature which encouraged me to develop a research study to assist in filling in those gaps.

Chapter 2: Literature Review

I drew upon research studies related to my study topic, in order to provide a comprehensive literature review for this section. This literature review is divided into seven sections focused on Indigenous women with an emphasis on colonization, residential schools, and the Sixties Scoop; intergenerational trauma; socioeconomic struggles; structural issues; substance misuse, and the importance of bonding and attachment between a mother and her child.

This research is important as there is a lack of literature examining the impact and understanding of Indigenous women's experiences in relation to her involvement with the child welfare system. This includes a mother's ability to bond with their baby during the critical period between the birth and when the mother and child are released from the hospital.

Colonization, Residential School, and the Sixties Scoop

Colonization resulted in the loss of culture, language, land, tradition, and livelihoods, as well as the removal of children from Indigenous communities. This removal of children from their homes and communities created trauma, loss, grief, and a lack of parenting skills (Ing, 2006; Rousseau, 2015). Children were considered the centre of Indigenous communities before colonization and were deeply valued and respected by community members. However, many Indigenous children are now removed from their communities, traditions and culture, creating a sense of cultural loss (Ing, 2006; Rousseau, 2015, 2018). Residential schools were created as part of the colonization and assimilation efforts (Ing, 2006; McKenzie et al., 2016). Children were torn from their communities, families, and culture and placed in residential schools where they experienced racism and emotional, physical, sexual,

and cultural abuse committed by the priests and nuns running them (Cull, 2006; Ing, 2006). The last residential school in Canada was closed in 1996 (Evans-Campbell, 2008).

There are three times as many Indigenous children in care as there were at the height of residential school enrolment (Cull, 2006; McKenzie et al., 2016; Trocme et al., 2004). It was noted in an annual MCFD monitoring report (2010) that, there were 910 children in care in the northern region, with 772 of these children being identified as Indigenous. Therefore, 79.6 % of the children in care in northern British Columbia as of December 2010 were Indigenous. The numbers have not changed much in the past ten years (McKenzie et al., 2016; O'Donnell et al., 2010; Rousseau, 2015; Trocme et al., 2004). Rousseau (2018) discussed that 62% of children in care in BC are Indigenous, while these children only make up 9% of BC's population. This research illustrates that the situation for Indigenous children and families has not improved over time.

The sudden increase in children being removed from their homes and their communities began in the 1960s and lasted until the mid-1980s. These children were often placed with non-Indigenous caregivers in Canada, the United States, and Europe, often leading to adoption. Social workers believed they were saving these children from poverty, unsanitary health conditions, unsafe housing, and malnutrition that they believed were rampant on reserves (Johnston, 1983; McKenzie et al., 2016). This phenomenon was referred to as the "Sixties Scoop." A Ministry of Human Resources worker, the equivalent of an MCFD worker today, first used the term Sixties Scoop in 1983 while referring to the influx of Indigenous children into care in the 1960s (Johnston, 1983). This worker described Indigenous children being scooped up from reserves at a high rate for almost no reason (Johnston, 1983). Johnston (1983) reported that there were 29 Indigenous children in care in

BC in 1955, but that number skyrocketed to 1446 Indigenous children in 1964 (Johnston, 1983). Johnston (1983) stated that some people understood social workers were attempting to save these children without considering long-term emotional effects, while others believed this influx of Indigenous children into care was a purposeful continuation of assimilation into western society. While many people have heard of residential schools and the Sixties Scoop, not many people know that the removal of Indigenous children is still occurring to this day and can be called the "Millennium Scoop" (Carriere & Richardson, 2009). The high number of Indigenous children in care can be attributed to the effects of intergenerational trauma, which is discussed in the following section.

Intergenerational Trauma

Intergenerational trauma refers to a situation in which "although the events involved may have occurred over many years and generations, they continue to have clear impacts on contemporary individual and familial health, mental health, and identity" (Evans-Campbell, 2008, p. 321). In addition, the trauma spans through generations and can be accumulated between generations as well (Evens-Campbell, 2008). Intergenerational trauma can cause mental health issues including anxiety and depression, impaired family communication and parenting skills, and the loss and breakdown of cultural traditions and values and beliefs, resulting in alcoholism, drug use, physical illness, and internalized racism (Aguiar & Halseth, 2015; Evans-Campbell, 2008). The displacement of Indigenous peoples, in addition to other possible traumatic experiences, affect not only a single generation; they are instead, felt through multiple generations (Cull, 2006; Denov & Campbell, 2002; Evans-Campbell, 2008; Ing, 2006; Rousseau, 2015).

Indigenous women experience discrimination, family violence, poverty, poor health, and sexual and racial violence at a disproportionate rate to non-Indigenous women (Niccols, Dell, & Clarke, 2009). Many Indigenous women report feeling the impacts of colonization, including loss of culture and land, residential school, and the forced removal of children from their families. These traumatic experiences are linked to substance use as a way to cope (Niccols et al., 2009). Indigenous families have high rates of poverty, substance use, young parents, unsafe housing, and parents who were abused as children, usually through the residential school or foster care systems (Evans-Campbell, 2008; Trocme et al., 2004). Shahram et al. (2017) identified Indigenous women as experiencing violence, poverty, and poor health which directly relate to intergenerational trauma.

Many Indigenous mothers discuss a lack of parenting skills due to their own parents' involvement with residential school, coupled with poverty and early motherhood, which often led to child welfare involvement (Bennett, 2008, 2009). It is important to acknowledge that many women, regardless of race, experience the loss of their child/children by way of the child welfare system. However, Indigenous women often deal with the additional stress of structural and societal racism and intergenerational trauma stemming from residential school and the Sixties Scoop.

Socioeconomic Struggles

Indigenous females who live in poverty are considered belonging to the most disadvantaged group in Canada (Cull, 2006). Many Indigenous mothers are affected by low socioeconomic status, racism, cultural loss, trauma, and exposure to violence, which increases the likelihood of adverse birth outcomes (Varcoe et al., 2013). Women of disadvantaged backgrounds such as minorities, and women living in poverty are unevenly

targeted and are often reported to the child welfare system (Cram, Gulliver, Ota, & Wilson, 2015; Marcellus, MacKinnon, Benoit, Phillips, & Stengel, 2015). Health and social services tend to focus more on illicit substance use, which often targets disadvantaged women, while prescription drugs are becoming more commonly misused in pregnancy (Benoit et al., 2014). Briscoe, Lavender, and McGowan (2016) stated that those who are vulnerable during pregnancy include "alcohol and drug users, homeless people, those sleeping in rough or transient accommodation, sex workers, teenagers or those who lack social support" (p. 2331), areas where Indigenous women are disproportionately reported.

Shahram et al. (2017) stated, "substance use among Aboriginal women is not a root cause of poor health and social inequalities but a response to complex social, political, and historical inequalities" (p. 256). Indigenous women who abuse substances are at a higher risk of involvement in the child welfare system, with Indigenous children being placed in care at a much higher rate, usually due to neglect (Niccols et al., 2009). This neglect is often caused by poor housing, poverty, lack of community and family support, and alcohol and drug use (Niccols et al., 2009). Many of the reasons Indigenous children are removed could be avoided if preventative work was done; however, often children are removed off reserves due to poverty-related issues (Cram et al., 2015). Carriere and Richardson (2009) discussed that over 60% of Indigenous children in care are there because of neglect that is directly linked to poverty.

Substance use while pregnant is considered by many to be a behavioural and personal choice and little to no responsibility is given to the systems or society involved (Reid et al., 2008). Families who deal with socioeconomic disadvantage are found to be at a higher risk of involvement with the child welfare system (O'Donnell et al., 2010).

Many Indigenous women were sterilized without their knowledge and through the legal authority given to medical professionals during the mid-1900s (Cull, 2006). The belief of the government was that Indigenous mothers were unfit and should not be able to procreate (Cull, 2006). This sterilization practice shows that Indigenous women have dealt with bias and racism in the health care system for almost a century. Indigenous people are often marginalized and experience much higher rates of infant mortality and adverse birth outcomes than the general population (Chen et al., 2015; Kildea, Kruske, Barclay, & Tracy, 2010). The idea that Indigenous mothers are unfit to mother can be shown in residential school policy, the Indian Act of 1876, and child welfare policies; these policies exacerbate negative stereotypes of Indigenous mothers (Cull, 2006).

It is important to look at socioeconomic struggles in relation to health complications of infants. As Hunter, Donovan, Crowe-Salazar, and Pedersen (2008) stated:

> It is difficult to assess the causes of damage to a newborn. If the mother used any cocaine, the assumption is often made that all of the damage to the child was due to cocaine when in fact there may have been multiple causes, including malnutrition. Most of these mothers are poor, some are homeless. (p. 5)

Research has shown that the notion that all babies will experience withdrawal symptoms due to their mother's drug use during pregnancy is false (Hunter et al., 2008). Infants can often be misdiagnosed due to health professionals assuming that normal behaviour such as crying is due to the mother's drug use. The Hunter et al. (2008) study in Scotland reported only 7% of 200 babies showed signs of withdrawal symptoms and only a few of those required medical intervention (Hunter et al., 2008).

Torchalla, Linden, Strehlau, Neilson, and Krausz (2014) completed a research study with pregnant and postpartum women who lived in Vancouver's Downtown Eastside. Torchalla et al. (2014) clearly showed how poverty, trauma, abuse, unsafe housing or homelessness, and lack of food could create a perfect storm for substance misuse and the removal of children by the child welfare system.

Structural Issues

Rousseau (2015) completed a research study with Indigenous social workers who were current or former employees at MCFD. The social workers in the research highlighted the child welfare system as racist, paternalistic, and culturally insensitive. This section provides literature associated with the structural challenges facing Indigenous at the birth of their child.

The use of racist language in the presence of Indigenous families and the inability of the system to understand the intergenerational trauma caused by colonization and residential school, has led to inappropriate judgments of Indigenous people (Rousseau, 2015, 2018). Many participants in Rousseau's (2015) research found several issues with the child welfare system (MCFD) that led to the unnecessary removal of children: systemic racism, a lack of cultural understanding, lack of support to changing practice, and an extreme aversion to risk. Many Indigenous social workers feel that the child welfare system is oppressive and racist towards Indigenous communities, leading to these workers being unable to serve their communities appropriately (Rousseau, 2015).

Reid et al. (2008) provided three lenses to examine discourse associated with mothers who use substances as rights, risk, and evidence. The rights perspective looked at enhancing a person's opportunity to have positive experiences in a societal context; the risk perspective

was determined by the actions or responses to certain issues; the evidence lens looked at the level of receptivity to knowledge and issues being discussed and where they originated (Reid et al., 2008). The often-debated mother's rights versus the fetus' rights view will be discussed in a later section.

Risk is a term that is used within the child welfare sector to determine what action needs to be taken to mitigate risk (Rousseau, 2015). Pregnant women who abuse substances are often viewed as high risk even if the mother's history indicates that she has stopped using the substance. Other external risks are considered less of a concern including, malnutrition, poor housing, homelessness, poverty, or domestic violence during one's pregnancy. This does not allow for a thorough assessment of pregnant women, as not all risks and socioeconomic concerns are considered (Reid et al., 2008). Reid et al. (2008) documented one mother whom stated: "They [the Ministry] don't really care about what this family's really going through. If they did, they would keep them together and work things out, if they're splitting them up at birth that is where the bonding is" (p. 219).

Reid et al. (2008) also noted MCFD fails to address and interrupt the cycle of intergenerational trauma, drug abuse, and poverty because of the paternalistic, racist, and Westernized system it employs. Many Indigenous mothers describe having to manoeuvre the system and jump through different hoops in order to keep their children or get their children back (Bennett, 2008, 2009; Hughes, Chau, & Vokrri, 2016; Hunter et al., 2008; Mather & Barber, 2004; Reid et al., 2008).

Cram et al. (2015) acknowledged that keeping Indigenous children safe is important, it is also complex. Indigenous children deserve to be safe, and these children and their families require culturally sensitive support to accomplish this. It is important to note that

Indigenous children are usually removed due to neglect directly linked to poverty and not from immediate harm, such as physical, emotional and sexual abuse.

Many hospitals provide an unsupportive, culturally insensitive, and racist environment for Indigenous women (Health Council of Canada, 2011; O'Driscoll et al., 2011). Many women report feeling treated poorly by nursing staff. For example, nurses have been known to tell Indigenous mothers they need to stop using drugs or get a tubal ligation (Hunter et al., 2008). Other mothers have had their culture and tradition completely ignored and disrespected by doctors and nurses who believe Western medicine is more effective (Health Council of Canada, 2011; Kildea et al., 2010; O'Driscoll et al., 2011).

Hughes et al. (2016) presented information regarding the impact of violence on mothers and the added difficulty which occurs when MCFD becomes involved. The authors noted there is often no support or intervention provided to address the domestic violence when circumstances arise where child welfare workers tell a mother to leave her abusive partner or risk losing her children. Mothers who experience domestic violence describe the feeling of trying to keep themselves and their children safe while also keeping their partner happy; when child welfare becomes involved, they make the mother leave or try to stop the partner's abuse without putting the appropriate supports in place (Hughes et al., 2016). The structures of society are created to oppress the disadvantaged, resulting in children from non-white, poverty-stricken homes being removed at a higher rate than other children (Hughes et al., 2016; Hunter et al., 2008).

Substance Use

Substance use is often the number one reason for the removal of children (Perry, Newman, Hunter, & Dunlop, 2015). Although substance use during pregnancy does not

solely predict maltreatment, it is the most likely factor in assuming child maltreatment and commonly results in the removal of children (Perry et al., 2015; Taplin & Mattick, 2015). Marcellus (2008) discussed that infants who are exposed to prenatal substance abuse generally come into care at an earlier age and access services for longer. It is estimated that between 50% and 80% of children who go into care in British Columbia were prenatally exposed to substance misuse (Marcellus, 2008). Niccols et al. (2009) and Crowe-Salazar (2012) indicated that twice as many Indigenous women compared to non-Indigenous women have disclosed heavy drinking and are overrepresented in women who abuse substances. However, the rate of abstinence of substance use is also much higher in the Indigenous population, which highlights the strength and resilience of these women (Crowe-Salazar, 2012; Niccols et al., 2009).

Many mothers who abuse substances admit that they need to work on their addiction, but state that they require a supported intervention where they can care for their child (Hunter et al., 2008; Reid et al., 2008; Shahram et al., 2017). Cull (2006) described Indigenous mothers as often being single parents, living in poverty and having to fight the negative stereotype of being an unfit mother.

Often mothers who use a substance while pregnant fear that their baby will be removed at birth, so they do not seek prenatal or other medical treatments. Women may feel motived to refrain from using substances during pregnancy, but when they attempt to access health care, they are treated poorly, or there is a lack of services and the substance abuse continues, resulting in the removal of their child at birth (Crowe-Salazar, 2012). Bennett (2008) reported that Indigenous mothers who have had their children removed have a lack of trust in the child welfare system and most live in fear of it. The complexity of stereotypes,

past trauma, and stigma associated with substance use while pregnant has led to fear for Indigenous women accessing essential health care for their pregnancy, including substance use interventions (Bennett, 2008; Crowe-Salazar, 2012; Hunter et al., 2008).

Bonding

The term bonding is often confused with the concept of attachment (Edwards, Phillips, Esterman, Buisman-Pijlman, & Gordon, 2017) and de Cock et al. (2015) explained that, while attachment is a well-known research area, the parent-to-child bond has remained under-researched. Multiple definitions of bonding and attachment theory with illustrations of the reason for focusing on the parent-child bond instead of child-parent attachment are presented throughout this section.

Edwards et al. (2017) described mother-infant bonding as the emotional connectedness between an infant and his or her mother. Redshaw and Martin (2013) described bonding as an emotional connection developed during a critical period immediately at birth where skin-to-skin contact between mother and baby creates a stronger bond and is thought to improve the child's long-term development. Rossen et al. (2016) defined maternal-child bonding as the emotional connection a mother feels towards her child; these authors describe the bonding process as beginning during pregnancy, as early as the first trimester, and strengthening through each trimester. Rossen et al. (2016) believed that a mother's felt bond to her child has a large impact on the child's social, emotional, and cognitive development. To further this description, Figueiredo et al. (2009) defined bonding as:

> A unique, specific, long-term emotional tie, which is established since the first contacts between the mother and the newborn and is facilitated by the mother's

> hormonal system as much as it is elicited by the presence of the neonate. When the mother's proximity and contact with the newborn is improved, the bonding is facilitated, and a more adequate mother-infant interaction is observed, leading to a better development of the child. (p. 539)

It is evident from these authors' descriptions that bonding is an emotional connection developed between a mother and her fetus during pregnancy and continuing between a mother and her infant at birth. This bond is believed to create building blocks for the child's cognitive, emotional, and physical development (de Cock et al., 2016; Edwards et al., 2017; Figueiredo et al., 2009; Redshaw & Martin, 2013; Rossen et al., 2016).

Attachment theory was developed in 1969 by a researcher named Bowlby. A central component of this theory is that caregivers must be present and available for children to become attached to them (Howard, Martin, Berlin, & Brooks-Gunn, 2011). To be attached is to feel safe and secure (Holmes, 2012). Bowlby noticed there were different types of attachment, and he described them as secure and insecure attachment (Holmes, 2012). The theory of attachment focuses on the proximity of a care provider and the reaction of a child when that care provider leaves and then returns (Holmes, 2012). Secure attachment is when a child is distressed when their caregiver leaves the room and can be comforted when they come back and return to normal behaviour. Insecure-avoidant attached children show little distress when their caregiver leaves and ignore them upon re-entry, and their play is inhibited. Insecure-ambivalent attached children are very distressed when their caregiver leaves the room and cannot be soothed once the caregiver is back, and they often switch between wanting to cling to the caregiver and fighting to get away. Insecure-disorganized attachment is where children are not sure how to react when their caregiver comes back into

the room (Holmes, 2012). Attachment theory is about how a child becomes attached to their caregiver and has a focus on proximity. A caregiver's actions influence the attachment style but ultimately it is the child's attachment to a caregiver that defines attachment theory. Bonding, on the other hand, is the emotional connection and response that a parent, more particularly a mother, has to a child.

Attachment theory is widely accepted and has been used in the child welfare system and in the separation of children from their parents (Choate et al., 2019). However, this thesis focuses on the immediate bond during pregnancy and at birth, not attachment theory (Figueiredo et al., 2009; Rossen et al., 2016). Figueiredo et al. (2009) suggested that bonding and attachment are interdependent, as the level of attachment from a child can influence the bond that a mother has towards her child. Based on the different descriptions and understandings of bonding and attachment, that bonding is developed in pregnancy and allows a mother to create an emotional closeness to her child and a desire to fulfil his or her needs; this, in turn, will impact the type of attachment style a child develops over time.

Bonding is essential to create long-lasting relationships between mothers and their children. De Cock et al. (2016), Edwards et al. (2017), and Figueiredo et al. (2009) suggested that the strength of a bond can determine a child's long-term development and ability to develop relationships. The more a mother can participate in the care of her child at birth, the stronger the bond will be (Figueiredo et al., 2009). De Cock et al. (2016) found that the feelings surrounding bonding remain consistent from the time of pregnancy until a child is 24 months old. This suggests the bond created by a mother and her fetus or infant during pregnancy and at birth can carry through the first two years of a child's life.

Separation of parents and siblings from family creates instability in many Indigenous women's lives; these women also report that the connection and bond to their family are significantly stronger than the experiences of abuse and neglect (Shahram et al., 2017). Greaves and Poole (2004) discussed emphasizing the importance of bonding and urge child welfare to put more resources into assisting mothers and children to stay together and create a bond rather than being torn apart. Greaves and Poole (2004) provided the narrative of one mother, who asked,

> How is it good that the kid doesn't bond with the mother? How could it be that the child you just gave birth to, this little person that is connected with you, like you just gave life to this child and then its taken away from you, because you need to go through all the hoops that you were supposed to. Like, it's hard enough to quit drugs and they should be more empathetic to the mother and not just thinking whether it is safer for the child to go somewhere else. . . . Wouldn't it be better [than placing the baby into foster care] to have a group-type home with the mother and baby in the house together and withdraw her that way? (p. 90)

Shahram et al. (2017) noted that the mother-child bond should be a top priority for relational reasons that will benefit both while maintaining child safety. Reid et al. (2008) provided numerous narratives by women who had used substances during their pregnancy. These women reported the importance of the mother and infant bonding at birth. The removal of an infant at birth is traumatic for mothers. Mothers report that even if the child is returned later, something is *missing* from the relationship as they were robbed of the essential bonding early on (Reid et al., 2008).

Babies who are born with Neonatal Abstinence Syndrome (NAS) can develop a bond with their mother when they can remain in the same room. NAS "refers to a postnatal opioid withdrawal syndrome that can occur in 55 to 94% of newborns whose mothers were addicted to or treated with opioids while pregnant" (McQueen & Murphey-Oikonen, 2016). This relational bond reduces the amount of medical intervention needed and increases the likelihood of the mother keeping children in her care (Newman et al., 2015). Wall-Wieler et al. (2018) stated: "Separation at birth disrupts bonding and can have serious consequences for both mothers and children, including increased aggression among children and increased mental health conditions and substance use in mothers" (p. 2). Newman et al. (2015) supported this notion in suggesting that interrupting the bonding and attachment of mother and baby can predict abuse, neglect, and infant abandonment, which is why it is essential to nurture the development of mother and child bonds.

The content in the literature revealed that an interruption of bonding or separation at birth could have serious consequences for both mother and child. Well-Wieler et al. (2018) indicated concern about the number of removals that occur at birth when many of these separations could have been prevented through harm reduction strategies and a complex understanding of addiction and trauma.

A Mother and Her Fetus

Focus on a mother's health while she is pregnant instead of on the fetus's health would allow the mother to become healthier and would result in a healthier baby (Hunter et al., 2008). The focus of media, public and social services concern is commonly placed on the health of a fetus, which turns into blaming the mother for making individual choices that harm her unborn child (Greaves & Poole, 2004). If MCFD representatives believed there was

a significant risk to a child, they would notify all British Columbia hospitals in writing and request notification when that child was born. This policy was recently rescinded and as of September 16, 2019 MCFD is no longer able to send birth alerts to hospitals. This popular practice has turned mothers into nothing more than "vessels" who carry a child (Greaves & Poole, 2004). The idea that the fetus is more important than the mother has led to a competition between mother and fetus, ignoring the socioeconomic struggles that plague mothers instead of putting an equal emphasis on maternal and fetal health (Greaves & Poole, 2004). The idea that substance abuse during pregnancy is caused by an individual's own abusive choice to harm her fetus, coupled with the lack of acknowledgement of poverty, mental health, trauma, and addiction, has led to policy and popular beliefs which fail to consider the complexities of substance use during pregnancy (Greaves & Poole, 2004). A majority of Indigenous women in the study by Shahram et al. (2017) who were abusing substances at the time of their pregnancy reported reducing or quitting their substance misuse, with all reporting a desire to quit using and to protect their unborn child.

Reid et al. (2008) discussed the importance of keeping the rights of children and the rights of mothers as equal and complementary instead of creating an environment pitting one against the other. Placing blame on a mother for using substances places all the concern and focus on safety of the fetus, often condemning the mother as an enemy (Crowe-Salazar, 2012). It is essential for health professionals, social workers, and policy makers to examine how policy outcomes result in the oppression of Indigenous women, especially those of whom abuse substances. It is also important to treat pregnant women who engage in problematic substance use during pregnancy, not as bad substance abusers but rather as good women worthy of receiving support (Crowe-Salazar, 2012). Crowe-Salazar (2012) stated:

> We took the risk in believing women with problematic substance use can be good, caring mothers and can care for their babies from birth, despite active substance use during pregnancy. It is incumbent on all of us who care for pregnant women with problematic substance use to insist on a woman-centered, harm reduction approach and to practice it. The lives of many women and infants depend on it. (pp. 267–268)

Perry et al. (2015) presented the need for an improved antenatal assessment for women who are considered high risk. Calder (2000) suggested that it would be helpful to determine a pregnant woman's level of risk early on to allow for time to plan for the mother and infant. However, Calder (2000) is a child protection worker and he did not look at cultural or socioeconomic struggles in his research. Instead, he looked at medical history, family makeup, family support, substance use, and feelings about being pregnant. He differed from Perry et al. (2015) on viewpoints of risk; the idea that there should be preventative work to prevent removals is a positive attribute of his research.

Dr. Abrahams, who works in the Fir Square unit at the British Columbia Women's Hospital in Vancouver stated, "Despite known risk and treatment factors, we continue to perpetuate the myths and misinformation, and harm women and children because we believe substance use during pregnancy is most harmful to a baby and that the mother is to blame" (Crowe-Salazar, 2012, p. 259). Fir Square was officially opened in 2003 and has five beds for pregnant women and six for postpartum women and their babies. It is designed to allow women and their infants to stabilize and withdraw from substances while remaining in the same room when possible (Crowe-Salazar, 2012). Fir Square offers counselling, medical care, life skills, parenting skills, and support with finances and housing, and it allows women to take ownership of their decisions in a safe, non-judgmental environment (Crowe-Salazar,

2012). More programs like Sheway and Fir Square in Vancouver are needed in British Columbia and across Canada to increase the success of healthy mothers and infants (Crowe-Salazar, 2012; Health Council of Canada, 2011; Hunter et al., 2008).

Conclusion

The focus of the literature review was to explore the impacts of colonization, the residential school system, and intergenerational trauma in relation to Indigenous women's experience with child welfare intervention at the birth of their child. The structural and socioeconomic struggles which impact Indigenous women because of historical trauma have led to an increase in the removal of Indigenous children from their families and communities. The literature revealed the notion of keeping mothers and children together at birth creates greater physical and mental health for both mothers and babies, and creates an inseparable bond (Bennett, 2008, 2009; Crowe-Salazar, 2012; Greaves & Poole, 2004; Hunter et al., 2015; Newman et al., 2015; Reid et al., 2008; Shahram et al., 2017).

Chapter 3: Research Methodology

This chapter highlights the methodological components used in my research, including the use of a qualitative, interpretive description approach as my research method. The participant sample, data collection methods, data analysis, and a description of the verification strategies to ensure rigour are also discussed. I highlight the ethical considerations of my research, the role of reflexivity, the dissemination of my thesis, and identified limitations of the research in the last few sections of this chapter.

Interpretive Description

Qualitative research is a field of inquiry which executes an interpretive view of an individual in the world (Smith, 2005). Qualitative research has many distinct branches to consider when conducting a research study, resulting in the choice of different qualitative methods such as phenomenology, grounded theory, and ethnography (Smith, 2005). Thorne, Stephens, and Truant (2016) noted that, while applied social science professions were drawn to qualitative research in the 1980s, there were difficulties in balancing the need for evidence-based research and the ability to apply the research to a vast array of individuals. Professionals in the applied social sciences were unable to fit their research questions into a conventional qualitative method. This resulted in the need for a new research method, Interpretive Description (ID), where results could be credible and relevant as well as implemented in the specified discipline (Thorne, Stephens, & Truant, 2016).

ID was created by Thorne, Kirkham, and MacDonald-Emes (1997) in the discipline of nursing. Thorne (1997, 2014, 2016) proposed the need for ID because most previous qualitative research methodologies intended to assure an unbiased researcher, approaching the research without assumptions and previous personal and professional knowledge. ID was

designed for people who try to "blend methodological integrity with a deep understanding of the nature of knowledge within the application context" (Thorne, 2016, p. 37). The goal of interpretive description is to "move beyond rule structures imposed by any disciplinary worldviews or standpoints that need not apply and replace them with more relevant and meaningful disciplinary logic" (p. 39). ID was designed to combine professional disciplinary experience with research and results that can impact real-life practice and highlight situations and experiences that professionals may face in their specific fields.

Social work has been my professional field since I graduated in 2011 with my Bachelor of Arts degree in social work. The overarching philosophy of social work is to believe in the intrinsic worth and dignity of each human being, regardless of beliefs, ethnicity or values (Hick, 2006; Reamer, 2018) and to uphold equal rights for all (Lundy, 2008). Social work looks at a person in their environment (Hick, 2006; Lundy, 2008; Reamer, 2018), the importance of human relationships (Reamer, 2018), and examines people in their environment while protecting the intrinsic worth and dignity of each individual. Interpretive Description is designed to combine professional disciplinary experience with creating positive changes for real-life practice. I believe ID is a good fit for my research because of the objective to look at the subjective experience of an individual and how these experiences can lead to knowledge for practitioners about what they may face in their practice, as well as the theory of social work being grounded in individual experience and social context. I was drawn to ID because it allowed me to bring my personal and professional experiences, beliefs, and values to the research endeavor; these professional experiences assisted in shaping my research topic and question.

Participant Sample

I used purposive sampling, which involves purposefully selecting participants based on specific qualities and circumstances (Thorne, 2016). The following inclusion criteria were developed to select participants and were listed on the recruitment poster (Appendix A):

1. The participant needed to be the birth mother of the child.
2. The participant had to be 19 years of age or older.
3. The participant had to have MCFD intervention at the birth of their baby—prior to the mother being discharged from the hospital**.**
4. The participant had to reside in Northern British Columbia.
5. The participant had to identify as being Indigenous.
6. The involvement with MCFD had to have occurred within the past 10 years.

I interviewed five Indigenous women who had contact with the child welfare system at the birth of their child, some of whom also had contact with MCFD during pregnancy. I chose to use a smaller sample, as it allowed me to gather rich data. Rich data "describes the notion that qualitative data and their subsequent representation in text should reveal the complexities and the richness of what is being studied" (Marx, 2008, p. 795). Thorne (2014) discussed sample size as an important factor in research, depending on what is being researched and how much research has been completed on the subject. For example, if a topic has been overly researched, a larger participant sample is needed so as to add information to the results instead of simply recreating them. However, if a topic has not been examined, then a small participant sample is believed to be a good starting place (Thorne, 2014; Thorne et al. 2015). Thorne (2016) discussed small sample sizes as being appropriate

as long at the researcher is able to recognize “there will always be more to study” (p.108). The term of saturation, or the redundancy of information during research, is well defined in qualitative research; however, Thorne (2016) believed it should not justify the conclusion of a study and that in fact, research claiming data saturation may not be credible, as new information can always be collected. That said, I felt confident that no new themes or information were emerging from the data, and I concluded that I had reached the point of saturation.

A small sample size of five research participants was appropriate for this research because there is limited research on MCFD intervention at birth specifically focused on Indigenous women, which was outlined in my literature review. The added importance of collecting rich data for this research as a novice researcher are factors that also played into my choice of a smaller sample size. Saturation was reached within the interviews as the participants began discussing similar narratives as the interviews progressed. The similarities between the five interviews allowed me to create similar themes and determine there was enough information to create rich, reliable data.

Recruitment Strategies

I provided my research recruitment poster (Appendix A), which was approved by the UNBC Research Ethics Board, to Maria Brower, Director of Harmony House, to display in the residential resource. In addition, I displayed my poster at the Prince George Public Library, downtown location, and Zoe’s Java Hut in downtown Prince George after obtaining permission from the staff at both locations. I completed three interviews, and three weeks passed without further interest, so I employed a snowball research sampling technique to recruit research participants. Thorne (2016) described snowball sampling as the ability for

individuals or professionals to identify potential research participants and give them the information regarding the research. I was able to share my poster with social work professionals in the community.

I received phone calls from potential participants and answered any initial questions they had regarding the research. I asked each participant if they had an opportunity to read the participant criteria on the recruitment poster. Potential participants confirmed they had read the participation criteria and we set up a time and location to review the information letter and consent form (Appendix B).

I ensured we met in a confidential location where the information being discussed could not be overheard. The initial meetings and interviews occurred in the home environment of the participants, in a private room. I read the information letter word for word to each participant. I asked if the participants had any questions or concerns regarding the research; some participants had questions which I immediately answered to the participant's satisfaction. All the potential research participants agreed to proceed with the interview after their questions had been answered and the consent form had been signed. Although there was an option for research participants to have a support person with them, none of the participants chose this option. Each participant received an honorarium of a $25 Tim Hortons gift card, as an appreciation for the valuable information.

Details of Data Collection

I decided to use individual interviews as my main data collection technique; individual interviews are often the primary source of data for ID (Hunt, 2009; Thorne, 2016). Once the participants had an opportunity to review the information letter, ask questions, and

sign the consent form the interview began. Each interview was conducted in a private room located in the participant's home environment.

I used semi-structured interviews as they are reported to be beneficial for complex and emotionally sensitive topics (Kallio, Pietila, Johnson, & Kangasniemi, 2016). Gathering rich data and ensuring trustworthiness in a study can be strengthened by using a semi-structured interview technique, as these types of interviews allow participants to focus on issues of importance to them and to express their unique views freely in their own terms (Kallio et al., 2016). Semi-structured interviews begin with an interview guide which asks all participants the same questions; however, these interviews allow participants the freedom to express themselves and invite researchers to ask individualized follow-up questions (Kallio et al., 2016). I had a list of ten open-ended interview questions (Appendix C), which were approved by the UNBC ethics committee. Ensuring there were consistent questions in each interview allowed me to keep the interviews on track, while also allowing me the flexibility to ask additional questions as they arose.

The interviews ranged from 34 to 82 minutes with an average of 40 minutes per interview. While the audio recording and interview lasted an average of 40 minutes, the total time spent with the participants was approximately two hours. This is important to note, as I was able to build rapport with the participants prior to the audio recorded interview. This time fostered a relational connection which generated rich data, as the participants felt safe. When I first met each participant, I introduced myself, explained the purpose of the research, I discussed my professional career, as a social worker and my role as a researcher, and I read the information letter verbatim. The participants were provided an opportunity to ask questions about the research. When there were no further questions, I reviewed the consent

form and each participant signed the form, at this point the audio recorded interview began. During the interviews, all but two of the women had their infants present and sometimes a break was needed for the mother to attend to her baby's needs. I documented notes during the interviews which allowed me to record additional questions; I also observed body language and the interaction between the mother her baby. The participants were made aware that I would personally be doing the transcription of their interview and that they were entitled to receive a copy. One participant let me know she did not want a copy of her transcribed interview; however, the other four participants requested that I phone them once their transcribed interviews were available.

Once the interviews were completed, participants were given the opportunity to ask questions or provide additional information. Most of the participants had follow up questions that were related to my role as a social worker. The participants wanted confirmation that what they disclosed in the interview was strictly confidential. I reassured the participants that everything shared in the interview was confidential as nothing was disclosed about child abuse or neglect, or harm to self or others. The participants were notified that they could call me with further questions or information at any time, as well as withdraw their consent for the research. None of the participants called with additional information or disclosed they wanted to withdraw their consent.

Data Analysis

ID research focuses on themes and patterns from subjective experiences to determine how they can be applied to a larger population and to practice (Wall et al., 2019). ID research requires that the research findings must be grounded in the data (Thorne, 2016; Wall et al., 2019). I used a constant comparative analysis technique for the analysis portion of my

research (Boeije, 2002; Hunt, 2009; Thorne, 2016; Wall et al., 2019), as well as a conventional content analysis (Hsieh & Shannon, 2005; Wall et al., 2019) to analyze the data for my research. I also kept reflective memos (Hunt, 2009; Wall et al., 2019) after each interview that were examined before each subsequent interview and were included in my data analysis.

Thorne (2016) described the importance of applying a constant comparative analysis of the data collected as well as concurrent data collection and analysis. This means that during the data collection and analysis, it is essential to compare the data collected and look for themes. It is also important to analyze the data as it is being collected, in order to constantly interpret the data, expand on it, and confirm, test, and explore the phenomena (Thorne, 2016, p. 109), which I did.

My data analysis began with the transcription of each interview. The shortest interview produced 15 pages of single-spaced data and the longest interview produced 25 pages of single-spaced data; the average was 20 pages of single-spaced data. As such, the interviews produced copious amounts of rich data. Using a constant comparative analysis, I transcribed the interviews verbatim and was able to immerse myself in the data during the transcription process. Thorne (2016) described the act of transcription as a powerful and emotional experience. It allowed me to observe the interviews from a different perspective than when I was conducting them. I was able to listen to each word and sentence, as well as experience the narrative in an in-depth manner. I transcribed the interviews verbatim and listened to the audio-recorded interviews again, in order to compare them against the transcripts and to ensure the transcripts were correct. Transcription provided another level of depth in a very intimate manner which assisted with the analysis process.

The transcription of each interview occurred before subsequent interviews occurred, allowing for constant comparative analysis. I reviewed the data of each interview prior to completing the next interview (Thorne, 2016). Reviewing the data allowed me to constantly compare the data and make notes of similarities and differences as they occurred, which Thorne (2014, 2016) communicated is an essential part of ID. Thorne (2014, 2016) suggested that by doing data analysis this way, the trustworthiness of the research increases, as there will not be an emphasis placed on one interview or one statement from a participant. I was able to develop a synopsis of each interview, which allowed me to maintain the overall story of the interview and avoid premature coding (Thorne, 1997; Wall et al., 2019).

Thorne (2016) cautioned against the use of excessive coding and Hunt (2009) suggests asking broad questions about the data instead of completing line by line coding and focusing on the "minutia of the data" (p. 1286). Thorne (2016) urged against over-coding in ID; she also identified that coding to some extent is essential for the data analysis process. She stated: "A good coding scheme is one that steers you toward gathering together data bits with similar properties and considering them in contrast to other groupings that have different data properties" (Thorne, 2016, p. 160). Thorne (2016) also suggested that inductive coding is an active process which allows researchers to look at data from different angles and be able to take the data apart and put it back together. This description of data analysis led me to use conventional content analysis for my in-depth analysis and coding of the data.

Wall et al. (2019) used conventional content analysis as an ID technique. Data analysis in conventional content analysis begins by immersing oneself in the data by reading and re-reading the data in the same fashion as a book would be read (Hsieh & Shannon, 2005). I began by transcribing the data, followed by reading and re-reading the data. I was

then able to document notes from my initial analysis along with first thoughts and impressions (Hsieh & Shannon, 2005). I also used reflective memos as part of the analysis process to ensure the completeness of the data (Wall et al., 2019). Immersing myself in the data by reading through them numerous times resulted in the ability to place importance on each interview and to begin identifying the development of similarities between the interviews.

Hsieh and Shannon (2005) discussed the next step of analysis as developing about ten to 15 clusters of codes. My initial analysis developed labels for codes that accounted for more than one initial reflection and placed them in clusters. The participants described feeling angry, sad, and furious; these were initially developed as individual codes as they were present in each interview. I was able to cluster these feelings into the larger theme of emotion, which allowed me to explore the participants' overall emotions regarding a child protection social worker from MCFD arriving in their hospital rooms.

Thorne (2016) suggested asking broad questions and trying to determine how bits of data fit into the whole picture, when testing relationships between data. An example of asking broad questions related to understanding why participants identified MCFD as always making decisions and giving direction. I was able to ask the broad question as to why this was, and it became evident through further analysis that MCFD held the power in their relationships with participants. This led me to develop a theme named "structural power imbalance," which includes three subthemes: feeling powerless, being watched and judged, and jumping through hoops.

Once the interviews were transcribed, I began my initial analysis of the transcripts. I contacted four of the participants (the fifth participant did not wish to be contacted) and

arranged follow-up interviews. I phoned the participants because they disclosed at the initial interview they preferred to be contacted by phone and wanted to receive their transcripts in person. One participant said she was interested but did not set a time or date, and three participants set a date and time to meet. One participant missed our follow-up meeting and I was unable to reach her in order to reschedule another follow up meeting. The other two participants completed a follow-up interview. I provided both participants with their transcripts and asked follow-up questions regarding their transcripts and their initial interviews. The other two participants completed follow-up interviews and were given their transcripts. I let the participants know to contact me at any time if they decided there was something, they would like me to change or omit. I reviewed the progress of my data analysis, and the two participants agreed with the themes that I developed and both agreed that I presented their stories accurately. The information I gathered at these two follow-up interviews was added to my data analysis. Thorne (2016) stated:

> Using repeat interviews as a mechanism for confirmation, clarification and elaboration on the essential relationships you are beginning to suspect within the overall data set is a powerful tool for helping you clarify what seems self-evident (but sometimes not articulated) to those involved, for surfacing the philosophizing they may have done about their situation, and for testing and understanding the experience. (p. 176)

The two completed follow-up interviews supported the development of my overarching themes and allowed for the receipt of positive feedback from the participants, which solidified the creation of themes. With the addition of the two follow up interviews I was able to complete a total of seven interviews. The follow up interviews each lasted

approximately one hour in length; I did not audio record these interviews but was able take notes, which were shown to the participants after their interview. I developed eight central themes and nine subthemes from my data analysis. These themes are presented in Chapter four and discussed in depth in Chapter five.

Ethical Considerations

I am a social worker actively working with Indigenous women who are involved with the local child welfare office in Prince George, BC (MCFD). I believe it was important to disclose my professional role to the participants. Skene (2012) urged that a researcher who is also a practitioner in the field needs to define their role to the participants before any consent form is signed. I informed the participants prior to the interview that I am obligated by law to report any information regarding child abuse or concern about personal or public safety, which is part of defining the researcher's role.

Skene (2012) discussed the difficulties faced when a researcher is a practitioner in the field, such as asking inappropriate or invasive questions leading the participant to discuss more information than intended. I made it clear to the participants that they could answer as much or as little of a question as they wished and that they could skip questions altogether with no consequences. The ten open-ended questions I prepared for the interviews (Appendix C) were non-leading and conscientious of bias. I strove to the best of my ability to ask questions in an open-ended, non-leading manner, in order to avoid influencing the participant to answer in a way that I assumed was correct. Fisher (2011) suggested another consequence of being a practitioner in the field as the risk of making blind assumptions and guessing the responses of the participant. This is important to note because if a researcher already assumes the outcome of an interview and/or the research, the results will likely follow the beliefs and

values of the researcher and not consider the importance of the interviews and the results they elicit (Fisher, 2011). It is essential to challenge assumptions and leave assumed knowledge behind during the interviews, in order to find the context and meaning in the narrative given by research participants (Fisher, 2011). I kept a reflective journal whereby I documented how I felt after each interview and documented any assumptions or biases I had regarding the participant interviews. I also arranged regular phone calls with my thesis supervisor, Dr. Tammy Pearson, to discuss the struggles I experienced between my dual roles of being a practitioner and a researcher. I developed strategies to address this paradox. The most effective strategy was writing in my reflective journal. I reviewed the journal on a consistent basis to ensure that I was not projecting my assumptions and bias during the interviews.

It is essential to acknowledge one's assumptions to ensure ethical research and reflexivity. I used this opportunity to discuss my assumptions as a first-time researcher and a practitioner conducting research. I witnessed many families in my professional experiences who disliked MCFD, as they believed they were targeted for being Indigenous. I entered the research assuming that the participants would describe their relationship with MCFD in a negative manner, given their cultural heritage. I also assumed that the participants would blame MCFD child protection social workers for any negative outcomes they had experienced during their involvement with MCFD. I assumed the participants would strongly identify as being Indigenous and acknowledge the role their identity played in their involvement with MCFD. These assumptions are addressed in Chapters four and five of the thesis.

It is important in ID to acknowledge the researcher's stance and experience (Hunt, 2009; Thorne, 2014, 2016). It is also important to allow research participants to discuss their own experiences without pre-made assumptions from the researcher (Fisher, 2011). I did not interview women I presently worked with or worked with in the past, in order to reduce the researcher-practitioner relationship crossover, and as an extra precaution to separate myself from the participants

The audio recordings of the interviews, interview transcripts, and any confidential information were kept on a password protected, personal computer, and stored as an encrypted file on Sync, which was recommended by the UNBC research ethics board. Any physical transcripts and the original audio recordings were kept in a personal safe in my home, to which only I had access.

Each participant was given a pseudonym upon which the participant and I had agreed; I explained the importance of anonymity to the participants and urged them to use a pseudonym that no one could identify. Skene (2012) suggested that even with pseudonyms and limited identifying information, there may be information or direct quotes presented that could identify a participant. Skene (2012) advised that inviting participants to review their transcripts will allow them to determine if any of the information would identify them; this is part of member checking to reduce this concern. During the member checks I advised the participants to read their transcripts to ensure that I did not use any identifiable information. The participants who read through their transcripts did not disclose any concerns regarding identifiable information. Skene (2012) suggested the importance of protecting participants exceeds the importance of direct quotes that may strengthen the research. Considering this, I ensured that any information provided in the findings section would not identify the

participants. As such, I changed gendered pronouns to child, infant, or baby; I also removed information regarding the age of the child or children and the identity of the social worker with MCFD.

The questions during the interviews were difficult so I provided a list of counselling services to each participant prior to the start of the interview. As stated previously, I also offered the participants to have a support person present during the interview, but none of the participants wanted a support person present.

Ensuring Rigour

Morse, Barrett, Mayan, Olson, and Spiers (2002) pointed out that research without rigour is useless and considered fiction. The importance of rigour in research has meant a large emphasis is placed on ensuring research is trustworthy by making it credible, dependable, and able to be confirmed (Morse et al., 2002). Qualitative research has been highly criticized by both quantitative and qualitative researchers for not being reliable, as there is no conclusive list of evaluative criteria for assessing qualitative research. To combat critique from internal and external sources, qualitative researchers have begun to come up with more defined strategies to verify qualitative research (Stige, Malterud, & Midtgarden, 2009; Morse et al., 2002).

I used the Stige et al. (2009) EPICURE model as the verification strategy for my thesis. EPICURE stands for engagement, processing, interpretation, critique, usefulness, relevance, and ethics. I have given a description of each concept below.

Engagement. Engagement is the constant and continuous interaction between the researcher and the phenomenon being studied. During this period, there is a necessity for reflection and reflexivity, and for the researcher to participate in the research and develop

emerging understanding and analysis of the research (Stige et al., 2009). I completed this process during my data analysis by using reflective memos, a constant comparative analysis. This required ongoing reflection on understandings created and data collected, and an inductive conventional content analysis. The follow-up interviews I conducted were also part of this process, whereby I continued to develop an understanding of the data.

Processing. Processing the data involved taking the information from the interviews and analyzing the data, preserving the data, and writing the findings. Part of the processing step involves the use of audio or video data and writing the observations from the interview (Stige et al, 2009). I did not use video data, but instead used audio-recordings and completed the transcriptions. I spent numerous hours immersed in the data, which allowed processing to occur. Once the audio recordings were transcribed, there were between 15 and 25 pages to analyze for each interview.

Interpretation. Interpretation is also part of the data analysis process, as patterns are identified and the researcher's focus of the data is examined. There is reflexivity concerning the researcher's role in shaping the data and how that may differ from the participant's understanding of the data. The interpretation process involves creating the context of the data in relation to the relevant field of study (Stige et al, 2009). I used my professional experience, values, and beliefs that created my thesis project through the use of ID methodology. The place I come from as a professional social worker defines what is taken away from the research. I ensured that each participant's interview was of equal importance as broad themes developed. Through follow-up interviews, I shared my initial themes with two participants who supported the themes derived from my inductive data analysis.

Critique. Critique refers to the assessment of the strengths and limitations of the research. In this instance, the term critique can refer to either social or self-critiques. Self-critique is defined in relation to the researcher and how he/she was able to maintain reflexivity in the previous engagement, processing, and interpretation steps. Social critique can be understood in terms of whether the research empowered participants and created social change or if the research has created a sense of disempowerment. Researcher reflexivity is especially important, because the researcher needs to reflect on why they are doing the research and the implications certain findings may have on individuals and communities (Stige et al, 2009). I discuss the strengths and limitations of my research thoroughly in a later section of this thesis.

Usefulness. Usefulness focuses on how the research can be used in a practical setting to solve real-life issues (Stige et al, 2009). Considering a central theme of ID is to take data and be able to apply it to issues faced by practitioners in the field; EPICURE was very relevant for my research thesis. Usefulness also includes how the data can become a stepping-stone for future research in the field. I discuss this topic in Chapter 5 under Practice Implications and Areas for Future Research.

Relevance. Relevance considers if research contributes to the development of literature associated with the specific discipline being examined. It can be more difficult to understand what the research provides to each discipline with multidisciplinary research. However, the focus is on the originality of the research, whether it fits with relevant literature, and how it has contributed to creating a larger body of knowledge (Stige et al, 2009). There is a gap in the literature regarding the experiences of Indigenous women with the child welfare system at the birth of their child. I contributed to the required literature in

relation to this topic during this research project and may extend that to publication of my work in the future.

Ethics. Ethics goes beyond trying not to cause damage with research; it should involve a desire to use research to support, empower, and benefit people. Three questions developed by Stige et al. (2009) were: "Is the research process respectful to all participants? Does the researcher demonstrate awareness of consequences of the research? How are issues such as confidentiality and informed consent handled?" (p. 1512). I strove to ensure the research was respectful by being an active listener while my participants shared their stories during the interviews. I also provided ample time for the participants to answer questions at their own pace. I aimed to understand the women's experiences from their perspectives. I was aware of the sensitivity of my research topic and provided each participant with a list of counselling services, as well as the option to have a chosen support person present. I ensured to the best of my ability that my questions were not contributing to colonization or filled with bias and assumptions. I ensured that no identifiable information of participants was disclosed. I read over the information letter verbatim with all participants to ensure they understood the research process. I also asked each participant if they had any questions or concerns before proceeding with the interviews. The participants' emotional safety and confidentiality were my highest priority, and I let them know they could call me at any time if they had questions or concerns about their interview or transcript, or wanted to revoke permission to use their interview.

A central focus of the EPICURE evaluative agenda is reflexivity in that the belief is that, researchers are not apart from their research but are instead positioned in it and must consistently reflect on this situation. Stige et al. (2009) and Rowe, Baldry, and Earles (2015)

highlighted the importance of reflexivity in research when involving Indigenous people with a non-Indigenous interviewer. Rowe et al.'s (2015) research provided a reflexivity guide with questions for the non-Indigenous researcher to ask themselves during research to ensure that bias and colonizing ideas are not introduced into the research. Some examples are: "What is the impact of my gender, race and class?"; "How does the research process impact on my 'self'?"; and "Am I actively seeking to deconstruct and challenge the hegemony of western knowledge systems, and thus meaningfully participate in the project of decolonization?" (Rowe et al., 2015, p. 304). I kept these questions in mind when developing my research questions, as well as during the interviews. I also kept a reflective journal that I wrote in after each interview and regularly reviewed to ensure I was maintaining reflexivity.

As a non-Indigenous researcher, I strove to work with the participants to fully hear their voices and to treat them as knowledge keepers in their lives (Rowe et al., 2015). There has been a history of social work practice and research which produces colonizing impacts and enacts Westernized ways of thinking. Rowe et al. (2015) suggested that many Indigenous peoples have been treated as objects in research, and Smith (1999, 2005) discussed how research involving Indigenous peoples tends to disservice them and continue the mechanisms of colonization and oppression. It was essential to tread with caution, and I ensured that I did everything in my power to empower Indigenous women and mothers, and to hear their voices and respect their knowledge both during and after the interviews.

Dissemination

Four of the participants discussed that they wanted a copy of my final thesis. I will call the four participants once the final thesis is completed and provide a copy. I will either hand-deliver a copy or sent a copy by email through Sync.

Limitations

It is important to disclose limitations of any form of research. I discuss the limitations I faced while completing my research. I was able to complete two follow-up interviews and confirm data themes with the participant. Follow up interviews with all participants would have been preferred.

All the mothers interviewed, except one, were able to keep their children due to living in supported housing, with staff provided. The other mother was able to live in a supported resource to get her children back into her care. It would have been ideal to have at least one participant who was not living in supported housing, as not all Indigenous mothers have this opportunity. This research focused on Indigenous women, and while it may be relevant to all women, the results maybe transferable to other Indigenous women, but may not be representational or applicable to the general population.

Another limitation is that I did not focus on the impact the removal or other MCFD intervention had on the child's biological father or extended family. While this information would be valuable, I was not able to include it as this was my first research project, and I needed to limit my focus.

Chapter 4: Research Findings

The themes and subthemes that emerged from the interviews are presented in this chapter. The main purpose of my research was to explore and describe the experience of Indigenous women who were involved with the child welfare system at the birth of their child. The participants were selected based on specific inclusion criteria such as identifying as being Indigenous, being nineteen years of age or older, and having child welfare involvement at the birth of their child as described in the previous methodology chapter. I consciously left out further participant demographics to protect the participant's anonymity.

I developed numerous themes and with further analysis, eight central themes with nine subthemes emerged from the data during my initial data analysis. The eight central themes and nine subthemes included: (1) the impact of child welfare involvement (including subthemes powerful emotions, trust, communication, and dismantled families); (2) a structural power imbalance (feeling powerless, being watched and judged, and jumping through hoops); (3) addictions; (4) socioeconomic struggles (young mothers and poverty, homelessness and neglect); (5) missed preventative opportunities; (6) the role of advocacy; (7) identity and culture; and (8) bonding. This next section identified and described the central themes and subthemes that materialized from the analysis of the research data.

The Impact of Child Welfare (MCFD) Involvement

The first central theme was the impact that child welfare involvement had on participants during pregnancy and/or at the birth of their child. It is important to recognize that under the umbrella of the Ministry of Children and Family Development (MCFD), several policies and services support the safety, health, and well-being of children, families, and communities. One of the roles of MCFD is known as child welfare (child protection).

The women interviewed for this research referred to MCFD in a way that implied the child protection stream rather than support services. In this chapter and the following chapters, I used the term MCFD frequently, as the participants each had interactions with MCFD social workers. Each participant had experiences regarding child welfare intervention and each was impacted by the involvement. The four subthemes that emerged from this central theme were: powerful emotions, trust, communication, and dismantled families.

Powerful emotions. Rowe et al. (2015) stated the urgency for Indigenous research participants to be heard and tell their story, which all five participants did. This subtheme was highlighted because the participants expressed their strong emotions in wanting to share their stories regarding their journey with the child welfare system. The participants had strong emotional reactions when a child protection social worker from MCFD arrived in their hospital room. These emotions were expressed in the interviews through words like fear, anger, fury, and hopelessness.

Janita stated, “Oh I was furious” when describing how she felt when the child protection social worker showed up in her hospital room twelve hours after she had given birth. She also stated:

> I pretty much wanted to bawl my eyes out and start kinda like why are you here? Who called you? Where did you get this information? But I couldn’t ask too many questions cuz she would feel and see that I was pretty angry and if I showed them that then that would have been something more that they can get on me about and if I cried that could have been held against me so I didn’t show any emotion, I didn’t want to.

Janita stated, “Because they’d [MCFD] hold on to it and just say she’s angry or needs anger management, she needs medication, things like that” when asked why she felt she could not show any emotion. Amy described her experience of the social worker arriving at her hospital room at the birth of her baby in this manner, “I was pretty scared,” “pretty freaked out” and “embarrassed and stuff.”

Butterfly Babe described that she was unaware of who MCFD was until her mother explained the role of MCFD. Butterfly Babe stated, “I dunno [about the experience of MCFD], um I, my mom was actually told me that, that MCFD was that like to take my child away and not going to be able to see her.” After this explanation, Butterfly Babe said “Ya exactly [about feeling scared] and that’s kind of how I see MCFD nowadays, they just want to take children away from Aboriginals.” She stated, “Um, I was really upset and I was actually worried” regarding when MCFD found out she was pregnant.

Veronica described that the team leader (supervisor of a protection team) arrived at her hospital room rather than her regular social worker. Veronica reported that the team leader “was dead set on removing the baby and I was infuriated, like how dare you come into my hospital room as soon as my baby’s born.” Veronica was “infuriated” that the team leader wanted to remove the baby and place the baby with a family member when she planned to breastfeed and felt that she had a plan with her social worker. Veronica continued to describe her experience:

> Infuriated. Like it’s just like, how dare you come into my room. I gave birth to my baby 13 hours ago and you’re gonna try taking my baby less than a day old, it’s just like yes babies can be on formula but that was not my birth plan and you’re gonna come in here and try, and disrespect that, I was just like absolutely not.

Amethyst felt "lost" when MCFD removed her child from her care at birth. She believed that she was able to keep her baby in a supported environment, but instead, her baby was removed from her care. Amethyst felt that MCFD had "sprung" the removal on her and given the "short notice" that there was not enough time to make alternative plans—she felt "abandoned." She described feeling confused and having a lack of understanding of why MCFD removed her baby, believing she was able to care for the baby. Amethyst described the one night she had with her baby in the hospital:

> When they [MCFD] apprehended the baby from me they called the social or foster mom, and she stayed the night in the hospital room and the day with me before they took my baby. I didn't even get my last night alone with my baby. I had to share it with another person.

The strong emotions of the mothers interviewed were evident in the data, as each mother described how she felt having MCFD arrive at her hospital room. In some of the above quotes, there appeared to be a lack of trust and communication with MCFD. This led to the subsequent subthemes—trust and communication.

Trust. It became evident while analyzing the data that the women had a sense of distrust of MCFD, and also that MCFD appeared to have mistrust with the mothers. This subtheme explored the lack of trust shared between child protection social workers and the participants.

Following the birth of Amy's baby, she had one relapse which did not occur in the presence of her baby. However, the social worker removed all of her privileges, and she was not permitted to leave her residence with her baby unless there was an approved supervisor present. Amy stated:

> They [MCFD] were just straight up and rude, but whatever, like um I was just like, you know, drugs have a huge grasp on people, it's a huge demon and I wouldn't be surprised if you relapse, and you know I'm working hard. I'm working harder than you're working, then I'm working harder than you … that's how it was, yep.

Amy discussed that social workers were rude because her drug screen was positive. She believed it was from Tylenol (3s) but said, "she [MCFD] didn't believe me. . . .and I even had a prescription to back it up and still she was just rude about it." Amy's statement showed the distrust that MCFD had regarding her situation despite the evidence that she provided. MCFD believed she had used illicit drugs when in fact it was a prescription. Instead of offering support to Amy, the social worker appeared to make accusations that may have been untrue.

Butterfly Babe discussed having a difficult time trusting MCFD. She felt MCFD did not trust her and were trying to deceive her by pretending to be supportive but trying to take her children. Butterfly Babe discussed that when MCFD found out she was pregnant "they were just like, oh she's unreliable, unable to be a parent." She said, "I honestly feel like MCFD is acting like they're happy for me, upset because they're not gonna be able to take my children now, even though they wanted to." Butterfly Babe did not want her social worker to know she was pregnant, and she had no trust that there would be a positive outcome if she disclosed her pregnancy. Butterfly Babe stated, "they [MCFD] seem like they're happy to see me better now, but I think they're also waiting for me to fail. At times they would say things that get to me." Butterfly Babe said she felt as if MCFD thought she was lying and making stuff up and did not trust her.

Butterfly Babe, Veronica, and Janita also hesitated to ask MCFD to purchase items for them or ask MCFD for any support, because they believed that MCFD judged them for seeking support. Veronica stated, “I always felt it [asking for help] was a form of weakness or if I asked for help then I’d be looked down on for not knowing how to do it, and that my child would be removed, so I did it myself.”

Veronica explained that she gave her social worker permission to be notified when her baby was born, but felt very deceived when a social worker came to the hospital with the intention of removing her child, which made her feel dishonesty preceded the relationship.

Janita explained that she was homeless and lived in a place with no electricity or heat while she was pregnant with her middle child, but did not want to ask MCFD for support because “I didn’t want them to apprehend my baby.” Janita went on her own to seek pre-natal support for her middle child. MCFD wanted to access the records, but she refused because “that’s none of their business, I said I came here for myself to make sure that you know I’m doing what I need to do.” Janita felt that MCFD was going to use the records against her and did not want them to have access to these records.

Amethyst discussed not trusting MCFD because when she was honest with them, they came and removed her children. She had a plan with MCFD for her children to remain with a family member. Her children had a difficult time being away from her, so they cried, and the family member returned them home to Amethyst. Amethyst called MCFD and was honest with her social worker by letting her know what had happened. The children were then removed. To further create mistrust, Amethyst believed she would be able to keep her baby at birth, but MCFD changed their minds and removed her child in the hospital room; there was no time for her to make a family plan.

Communication. The term communication had two meanings in the context of this research. The first was related to the minimal communication between MCFD and the mothers due to lack of telephone contact or MCFD not returning calls. The other part of communication involved the manner in which MCFD and the mothers communicated with one another.

Amy reported that a child protection social worker called her during her pregnancy after MCFD received a report. The social worker called her once and discussed concerns, then called about two weeks later. Her phone was then cut off and MCFD did not make further contact until they showed up at the hospital.

Amethyst discussed having five different social workers, three of whom she had never met. When asked why she never met three of her social workers, Amethyst stated, "Probably because they had a hard time getting in contact with me and I had no way to contact them but case got bounced around quite a bit."

Veronica mentioned that she was approximately two months pregnant when her MCFD social worker learned about her pregnancy. According to Veronica, no planning was completed with her in preparation for her baby's birth. Veronica worked with the social worker for seven months of her pregnancy to discuss her other child, but there were no meetings or communication regarding her pregnancy. Veronica said her social worker indicated she could not reach her, but Veronica believed "it's just like if I've got two people [service providers] that I've never met that could search my name on Facebook or try the last recent phone number and get a hold of me, you clearly did not try hard enough." As well, Janita discussed having a difficult time getting in contact with MCFD: "It takes about four days to get a hold of them [MCFD]. I'm calling left and right, it's like phone tag, they're not

tagging me back." Janita also did not understand why MCFD was conducting numerous drug tests on her middle child in the hospital, and she felt there was no communication about the process or the purpose of the drug testing.

Butterfly Babe discussed that her parents were mean to MCFD when she was a child, as they yelled and swore at the social workers and that on one occasion, she expressed the same behavior which MCFD held against her. Butterfly Babe said she was unable to show any emotion, especially anger, toward social workers because they would refuse to speak with her. In order to prevent yelling, she had to go for walks to calm down before and after communicating with MCFD.

Janita said that when MCFD communicated with her, they are disrespectful and give her attitude and "she [social worker] made me feel like I was really beneath her." At our follow-up interview, Janita said she was still having difficulties getting hold of her social worker; she stated, "they're [MCFD] not really answering me."

Much of the communication between the participants and MCFD was negative, but there were some examples of how positive communication made the women feel optimistic. Amethyst described her child's foster parent as being nice because she "always sends me pictures and lets me know how my baby is doing." Being able to connect with the foster parent gave Amethyst the chance to be part of her baby's life, which she stated was positive. Amethyst also discussed having a positive relationship with her current social worker and described her as awesome. I asked Amethyst what qualities her social worker portrayed to be described as awesome. Amethyst stated,

> Um just the fact that I know she's trying and she wants us to be back together and um I know that she likes uh keeping in contact with her and I have those conversations and just let her know what's going on and how I'm feeling.

Similarly, Veronica believed that since she and her social worker started trusting each other and communicating,

> We were able to talk together very well and we were able to make a deal like almost two times a month at meetings and it was very nice to be heard and like talk about how well things have been going.

Dismantled families. The final subtheme flowing from the main theme referenced dismantled families due to "Impact of MCFD Involvement." This subtheme had a large impact on the participants as MCFD dictated which family members they were allowed to see.

Amy discussed being unable to see her baby's father due to MCFD's concerns regarding his previous drinking and domestic violence. She also stated that she was not able to see healthy family members who resided out of town—MCFD stipulated that she reside in Prince George for a significant period of time prior to travelling out of town. This was difficult because her mother lived out of town, and Amy was not able to visit her baby even though her mom was supportive and healthy.

Butterfly Babe discussed that fathers should be included in supporting and planning for their children, and that all of the responsibility should not be placed on the mothers. Butterfly Babe was forced to stay in Prince George instead of her community in order to keep her children in her care. This meant she was not able to see any family, which included her grandmother who was a positive support.

Veronica was pregnant with her first child and resided with her sister and her sister's children when she required mental health support and was admitted to the hospital. This resulted in MCFD receiving a child protection report. The report resulted in a social worker informing Veronica that she could not stay at her sister's home, despite the fact that they were each other's support. MCFD gave the impression to Veronica that they thought she was an alcoholic and should not be around children. The social worker advised Veronica that she could access services for her pregnancy in a different community but did not offer ongoing support or services. Veronica stated,

> She [her sister] was always there for me so it broke my heart when she couldn't be there for me and I didn't want her to lose her kids because of me and I think she felt equally as upset.

Veronica was teary and emotional during this statement. She was not able to stay at her sister's home so she went to her adoptive parents' home to stay, but because they had children in their care she was not allowed to stay with them. Veronica was separated from all her healthy supports for her first pregnancy. "It broke my heart more when my parents couldn't help me," she stated.

Veronica also mentioned that she was not able to spend time with anyone over the age of 19 unless they had had a criminal record check, which pushed some of her family and her friends away. They did not want to go through a criminal record check or have MCFD involved in their lives again. Veronica's sister "kinda kept her distance cuz she wants absolutely nothing to do with MCFD cuz she had prior MCFD with her child." At the follow-up interview with Veronica (a month after the initial interview), Veronica stated that her

sister was not willing to meet with MCFD, as she was scared they would become involved in her life.

Janita was unable to see her partner unless her child was not present or it was a supervised visit. At the follow-up interview, Janita said she was allowed in the community with her child but did not want to go because she was not allowed to see her child's father. Janita discussed her thoughts about MCFD and their role in Indigenous families. She reported, "they're trying to help the children, but they're not, they're there for the children, but you know that they're supposed to be helping the families get them back." Janita revealed feeling that she was forced to be away from her partner and her other child, who was in foster care.

Amethyst discussed that neither she nor her children were able to be in contact with her partner. She stated that MCFD is "breaking up a family." It was evident during the interview that she believed that she and her partner had made many efforts to change, in order to keep their children together. Amethyst stated, "the more support for the family to change for the better not just trying to separate us, past dealings with the law or whatever shouldn't be able to use somebody's past when they're trying."

A Structural Power Imbalance

The second central theme was a structural power imbalance involving the inequality in power when dealing with MCFD. Each participant discussed anywhere from one to seven MCFD social workers that arrived in their hospital room within 12 to 24 hours of giving birth. In some instances, these women had C-sections and had to manage their pain associated with surgery, the joy of seeing and holding their infant, and the fear of losing their new infants simultaneously. Some women faced MCFD with each child they delivered.

There were three subthemes included: feeling powerless, being watched and judged, and jumping through hoops.

Feeling powerless. The feeling powerless subtheme arose because all of the mothers mentioned they had MCFD safety plans, but most had a limited understanding of the expectations and conditions MCFD placed on them in order to prevent a removal. The lack of understanding of the participants led to unwarranted actions by MCFD.

Butterfly Babe, Veronica, Amethyst, and Janita all stated they believed they had appropriate caregivers or babysitters watching their children when they left home. Regardless, their children were removed or MCFD became more intrusive. The participants discussed that the MCFD's action led to confusion as they felt they left their children in an appropriate place, but felt punitive measures were taken by MCFD. Amethyst described her confusion with the safety plan MCFD created and remembered the social worker had to re-write the safety plan as initially it was not correct. While describing the MCFD safety plan, Amethyst stated, "she [social worker] stated it wrong which made it unclear, the supervisor made her rewrite it because it was unclear in the first one [safety plan], it'd be the reason they [children] were apprehended." Amethyst discussed that the safety plan was the reason her children were removed as she did not understand or agree with the plan and felt pressured to sign it. Amethyst stated, "I don't even remember what their [MCFD] expectations were or what the safety plan even said" and "I don't remember exactly what it [safety plan] was but if I understood it fully then it [children] wouldn't have been apprehended." Amethyst discussed doing anything possible to keep her children, but she did not understand the safety plan, so she felt she could not comply with it.

Janita remembered not wanting MCFD to come into her hospital room but felt that she could not say no, so she agreed—she had a five-minute warning prior to MCFD arriving. When MCFD social workers came to Janita's hospital room for her newborn, they said, "do you know what are you doing um when you get out of the hospital because you won't have your child with you." Janita reported that her advocate, coupled with the supportive housing environment in Prince George, were instrumental in the fact that she was able to keep her newborn in her care. In the absence of these supports, her child would have been removed at the hospital.

Veronica described the first few times she met with MCFD without advocacy: "it was very, very hard like it was always upsetting, it was very frustrating because I felt my voice was not being heard." Butterfly Babe felt that no matter what steps she had taken, MCFD was going to remain involved with her children subsequent to the birth of her child. She believed that residing in a supported resource environment, maintaining sobriety, and accessing services made no difference to MCFD. MCFD told her they would remain involved after she gave birth. The feeling of powerlessness was evident, as no matter what action she implemented, MCFD would remain involved in her life.

Amethyst described feeling the reduced advocacy and support from MCFD and community programs after her children were removed. Amethyst stated, "it's totally different when you don't have your kids with you … it's like you're not a mother unless you have your kids with you kinda thing." She did not know what she needed to do in order to keep her children in her care or have them returned. There were no supports offered by MCFD, but they expected her to follow their expectations. Amethyst described feeling unsupported and lacked the knowledge to attend various programs.

The participants' feelings of powerlessness were in the language they used to discuss their interactions with MCFD. They used language like MCFD "let me" or that they were "willing" to work with MCFD. These phrases demonstrated that MCFD held the power, as they were "letting" participants keep their children and participants kept their children if they were "willing" to work with MCFD according to their standard. Amy stated, "my social worker just said if you work with us, we'll work with you" and when MCFD was rude to Amy, she just said, "it is what it is…right?" Butterfly Babe felt she had to "prove" herself to MCFD. Janita discussed moving forward and said she was "done dealing" with MCFD. The social worker dealing with Janita told her she would "have" to do this or "have" to do that but not that she "needed" to or "should." Amethyst said she believed MCFD was going to "let" her "keep" her baby, but then after the baby was born, the MCFD supervisor "changed their mind" and "they [MCFD] took baby."

The language that the participants used to discuss working with MCFD clearly illustrated that MCFD held the power in these relationships. It was also clear that if the participants were "willing" to work with MCFD, they had a better outcome than those who showed anger or frustration towards their social worker.

Being watched and judged. The subtheme of Being Watched and Judged emerged because the mothers stated they felt that MCFD was constantly watching them and that they were being judged for every action they made or did not make. The pressure this put on the mothers was at times overwhelming and difficult.

Amy compared her experience with MCFD to a supervisor who was "watching me all the time" with her baby. Butterfly Babe stated, "they [MCFD] kept an eye on us," "they're always involved with me," "they're probably still going to be involved [discussing not

drinking anymore],” “they’re going to stay involved” and “keep a close eye on me.” Butterfly Babe believed that no matter how much progress she made, MCFD was going to remain involved and keep an eye on her. She said that she wanted MCFD to change their outlook about her situation and to see her for the person she has become, not to judge her for her past actions.

Veronica remembered the time when she saw her child in the community. Her child ran to her and said hi and the foster parent said “well it’s not like you will ever get her back you’re just an addict, and I was just like that was kind of upsetting because I’d already been clean so long and I did not like her.” Thankfully Veronica was able to advocate for herself and had her child moved to a different foster home. Questions remained for Veronica—how did that foster parent know about her details, and what had MCFD shared with the foster parent? Veronica also described feeling that MCFD was watching her and she did not know how she was going to “get them off my back.”

Amethyst felt she had to explain that two of her children had health struggles that were not related to Fetal Alcohol Spectrum Disorder (FASD). She assumed that people would make that judgement when they heard that two of her children had health difficulties. Amethyst felt she had to clarify that her children had health concerns that were out of her control and that she had not caused the associated health concerns. As a result, she felt judged.

Janita stated that she saw a social worker when she was pregnant and the social worker said, “see you again, and I’m like, what? She’s like, oh I’ll just see you around…I’m like ok…I left, and I’m like uh I don’t think so.” After this encounter, a birth alert was put on the system and MCFD was aware that she was pregnant. Janita stated, “I know they’ll

[MCFD] never leave me alone, but I was still on watch after my oldest was born." She felt that MCFD had watched her for over 10 years, as they arrived at the hospital at the birth of each of her children. Janita discussed that MCFD always kept an eye on her and judged her as a mother.

Jumping through hoops. The literature in Chapter 2 refers to the phrase "jumping through hoops" which has been consistently used by Indigenous people involved with the child welfare system. In the case of this research, this subtheme was created as the participants discussed the hoops they had to jump through in order to satisfy MCFD's expectations—to keep their children in their care.

The participants expressed that they had to leave their communities for medical support during their pregnancies and/or MCFD had required some of the participants to relocate to access specific supports. All the participants were required to live in supported housing, located in Prince George, in order to keep their children in their care. While complying with this expectation, there were additional conditions placed on the mothers.

For example, Butterfly Babe described that MCFD expected her to complete numerous programs and advised her where she had to reside with her children. She believed MCFD had their own plan created for her—where she had to live and what programs she had to attend. She stated, "I've been through their hoops pretty much, I've been dealing with them, been doing what they want me to do, I broke down once with them, and that's what got me, they're really hard people to deal with, really hard people to deal with."

Veronica discussed how hard she fought to get her older child returned to her care and how frustrated she was in the process. Veronica stated,

> I've gotta play their [MCFD] game I have to jump the hoops and do what they can but you can only jump through so many hoops before you start getting frustrated and start going back to your own ways where you start losing hope and faith that this is ever going to end.

Veronica had dealt with MCFD for over a year and felt that no matter what she accomplished, MCFD was going to expect more of her, and she did not know what she needed to do in order to have her child returned to her care.

Janita discussed that she felt frustrated when it comes to MCFD's expectations, "I had to jump through their [MCFD] hoops and hoops and hoops and then I jumped hoops to make sure that they would leave me alone after." She stated that she dislikes all social workers and felt that they were making matters worse for her, even though she had jumped through all of their hoops. Janita stated, "Because they [MCFD] want us to go through hoops and hoops and hoops and we've already been through the hoops like uh the supervision order with my other child." Overall, Janita's experience with MCFD was negative. At the follow-up interview (month after the first interview), Janita remained frustrated with MCFD and described that MCFD had many expectations for her and her partner, and she felt she was making progress and adhering to the expectations, but MCFD failed to make any movement on their part.

Addictions

Each participant discussed the impact addictions had on their lives and their relationship with MCFD. Addictions emerged from the data as the third central theme. In each interview, there was a discussion about alcohol, and most interviews involved a discussion regarding illicit drug use. Addictions impacted each of the participants because

they or members of their family struggled with some type of addiction. The participants stated that they were tested for substance use at the birth of the baby, and additionally their infants were screened for drugs to determine if there had been recent use. Drug screening was completed through urinalysis and, at times, by the way of blood work. Some of the mothers were not aware of what the tests were for and they stated their infants were poked with needles, often numerous times.

Amy reported that MCFD provided her with an ultimatum without offering support services to manage her addiction:

> I think that the social worker, the second time she called said if there's any drugs in your system when you give birth then you we're gonna take your baby like it's not going to be okay…but they said you know if there's no drugs in your system then we'll be okay…right.

Amy was quite ill during her pregnancy due to a health condition. She used drugs to cope as she believed her illness was due to being dope sick; it turned out to be a medical issue which the health professionals were unable to diagnose until she went into labour. Amy tried to quit using drugs while pregnant, she tried suboxone in attempts to quit, but nothing worked, despite numerous doctor and hospital visits. Although Amy had used drugs for numerous years, she stopped using as soon as her baby was born and has maintained sobriety with the exception of one relapse.

Janita was unaware that she was pregnant and consumed alcohol during her pregnancy. She realized she was pregnant when she went into labour. Since Janita's baby was born, Janita has maintained sobriety. Janita shared that she was not permitted to take her baby in the community for the first month after she gave birth to her baby. MCFD was

concerned she would relapse and consume alcohol while caring for her baby. Janita indicated that when she was out in the community and she saw her family members along with other people from her community drinking alcohol, they encouraged her to drink with them. Janita maintained her sobriety although alcohol was offered to her in the community. Amy discussed the social pressure and expectations around drinking alcohol and that it is normalized and expected of people.

Although Janita consumed alcohol through her pregnancy, she attributed her drinking to the fact that she was unaware that she was expecting. Janita had not used drugs or alcohol during her previous pregnancies: both she and her children tested negative for substances at birth. Janita stated that MCFD's concern about her previous pregnancy was, "Drinking, using drugs and needles"; however, she tested negative at the birth of her baby.

Janita, Butterfly Babe, and Veronica all stated they were drinking prior to their children being removed, but all had babysitters while under the influence. Butterfly Babe discussed keeping her children safe by only drinking when there was a babysitter watching the children. Butterfly Babe indicated that she used to drink alcohol but no longer does and that MCFD has told her they were concerned that she was going to relapse. Veronica admitted that she struggled with an addiction before her child was removed, but she had left her child in the home of an appropriate caregiver and was not drinking in the presence of her child.

Amethyst discussed her addictions and that she had a "slip" when she was pregnant and believed it brought on her labour. She described that MCFD needs to be understanding of mothers who have addictions. Amethyst was tested for substance use when she gave birth. She had slipped the night before, producing a positive drug test resulting in the removal of

her baby. Amethyst discussed that MCFD needs to be supportive of mothers who have addictions and not do everything by the book. She said, “MCFD goes a lot by the books but a lot of the times you need to be able to put yourself in that, in that person’s shoes.”

Medical tests were administered after Veronica’s youngest child was born to determine if she had used any substances. Veronica stated that after her first child was born, “we both had to do a urinalysis for MCFD . . . they [MCFD] did many drug tests on me and my baby and they kept poking and poking and poking for about three days.” Amy also reported that she and her child were also tested for substance use at her baby’s birth through urinalysis.

Socioeconomic Struggles

Socioeconomic struggles were identified as the fourth central theme. The participants reported that becoming a mother at a young age, as well as homelessness, poverty, and neglect, were all factors that contributed to the involvement of MCFD during their pregnancy and at the birth of their child. Two subthemes flowed from this central theme—young mothers and homelessness, poverty, and neglect. Homelessness, poverty, and neglect were clustered as one subtheme.

Young mothers. Three of the five participants discussed having their first child at a young age. These three mothers were 16 years old when they had their first child. Butterfly Babe described that MCFD arrived at the hospital when she was 16 years old to remove her baby and she reported that the removal was due to “having my child at a young age” and “I was just too young.” She remembered when MCFD entered her hospital room and asked if she wanted to place her baby for adoption. MCFD failed to ask her if she planned to keep her child. MCFD wanted her to finish her education and she remembered them telling her that

she could parent when she was older. While Butterfly Babe's child was placed with family, she helped parent her child, but MCFD did not allow her child to be alone with her due to her young age.

Janita was 16 years old when she had her first child. In response to a question, why MCFD was involved? She stated, "I was underage, and I actually woke up to seven social workers in my room." These social workers arrived when "I was actually at the time trying to breastfeed my baby." Janita stated that when she was 18 years of age she secured independent living and at that time was able to parent her child. Until then, Janita was placed with her infant in foster care in order to be supervised.

Amethyst stated, "My child was born with a disability. I had my child when I was 16 years old." Amethyst explained that her child's disability was due to a natural birth defect and was not a result of her actions. Amethyst shared her experience of what it was like to be a teenage mother and discussed that her child lived with family members.

Homelessness, poverty, and neglect. This subtheme highlighted the role that homelessness, poverty, and neglect played in the participants' lives, which resulted in MCFD's involvement. I compiled these three factors into one subtheme, as all the participants touched on each factor to different extents.

Butterfly Babe said that MCFD removed her other children due to neglect, but she did not believe that she neglected her children. This previous concern prompted MCFD's concern for her most recent pregnancy. Butterfly Babe stated:

> … because [when discussing what MCFD meant by neglect] I left my children with babysitters overnight and apparently they would be like or changed their clothes and or I would never bath them whenever they needed a bath. They [MCFD] wouldn't

> know because they only look like that because I was staying with my grandma and even though I hadn't had extra clothes for and my child's clothes got dirty I would take them off and let her run around in her diaper. And I would wash my child's clothes and put them on but it looked like I just kept my child in the same.

The concerns Butterfly Babe discussed were factors associated with poverty, which appeared as neglect and prompted MCFD involvement. Another example of poverty that impacted the mothers' ability to communicate with MCFD was related to their inability to secure a landline or a cell phone. This was described by Amy and Amethyst who did not have access to a cell phone or landline during their pregnancies, which made it difficult to plan with MCFD.

Amethyst, Janita, and Veronica all reported that they were homeless during their pregnancies. MCFD informed Veronica that she was not able to reside with any of her family members, which included her sister and parents, due to other concerns. Veronica stated, "I was struggling with homelessness, not having a place to stay for myself or anywhere" and "it's just like I just battled it by myself and made sure that if I couldn't eat myself that I was at least eating enough to keep my child healthy." Amethyst discussed that she had to return to Prince George so she could have visitation with her children. It was difficult to arrange visits, as she was "homeless" while in Prince George. Another participant, Janita, stated that she was "staying in a motorhome with no electricity, no heat, it's very hard to find rent in my community and this was during the winter." It was evident in the interviews that these factors impacted their lives.

Missed Preventative Opportunities

The fifth central theme that emerged from the interviews was missed preventative opportunities. All but one participant had multiple children and had previous MCFD involvement. The most recent birth of their child was not their first contact with MCFD. However, four out of the five participants were not offered any supports from MCFD during their pregnancy. The lack of preventative support was evident while speaking with the participants. MCFD social workers informed the women that they were unable to reach them in order to plan. Communication between MCFD and the expectant mothers was limited—if any at all.

Veronica described being involved with MCFD regarding her first child when she became pregnant for the second time. She stated that if MCFD had offered her supports and reached out, she would had felt that they cared, and would have felt more comfortable asking for support. When Veronica was pregnant with her first child, MCFD became aware of her pregnancy when she was about fourteen weeks along. At this point, MCFD did not offer supports or engage in planning with Veronica. With Veronica's second child, a social worker was aware of the pregnancy for seven months and no planning was done. At the birth of her second child, a team leader from MCFD arrived in her hospital room and attempted to remove her infant. While Veronica kept her baby in her care, she had to adhere to strict conditions outlined by MCFD. If planning had been done for the previous seven months, Veronica could have had a different outcome for both of her children.

Janita was unaware that she was pregnant with her youngest child, so MCFD did not have an opportunity to offer any support services. However, with her middle child, a social worker knew she was pregnant early on in her pregnancy, but she was not offered any

support. I asked why she did not request support services from MCFD. She stated the following: “I didn’t want them to apprehend my baby.” Janita expressed that she would have accepted support from MCFD if it was offered but she did not feel comfortable asking for help.

Amethyst was involved with MCFD during her pregnancy; however, she did not understand MCFD’s expectations. In other words, she was not clear on what was expected in order to care for her baby at birth. She had no idea that MCFD planned to remove her child, even though MCFD was involved during her pregnancy. Amethyst stated: “Ya, and if there was something that I could have done before I had baby to make it so they wouldn’t have [apprehended the baby], I probably would have done it” and “I am a good mother, and I would do my best to keep them. I have no resources or not having the knowledge of what I’m supposed to do.” It was clear that she lacked the understanding of MCFD’s expectations which led to missed opportunities.

Amy discussed that a social worker reached out to her when she was five months pregnant after a report was received by MCFD. According to Amy, the social worker reached out to her two weeks after the first phone call. Amy had no further contact with MCFD after the second phone call because her phone was out of service. The next time Amy heard from MCFD was when they arrived in her hospital room. In contrast to the other women, Butterfly Babe had planned meetings during her pregnancy, as her advocate supported her through the process. This prior planning prevented MCFD from arriving at the hospital at the birth of her baby because a safety plan had been developed and implemented.

The Role of Advocacy

The role of advocacy was the sixth central theme that was evident throughout the interviews. All of the women in the research experienced advocacy and support in different capacities. In fact, all of the participants discussed having positive experiences with health services, which included doctors, nurses, and the social worker at the hospital.

Janita was the biggest cheerleader for having an advocate. She believed that her advocate made all the difference in terms of the outcome with MCFD. Janita mentioned her advocate throughout her interview. She reported, "If I used an advocate when my oldest and my middle child were born, I'd never have to deal with MCFD." I asked Janita what factors would encourage Indigenous women to ask for support during pregnancy? Janita said, "Um, I guess just being told that you know there are advocates … they're a lot of help now that I have one." Janita discussed that she had a difficult relationship with her MCFD social worker and did not like her. She stated that her advocate was the one who communicated with her social worker.

Butterfly Babe had a support worker from Carrier Sekani Family Service (CSFS) who informed MCFD that Butterfly Babe was pregnant. Butterfly Babe was offered a supportive residential program to mitigate MCFD's concerns. This preventative action supported Butterfly Babe in the development of a plan that allowed her to care for her babies at birth. Similarly, Veronica had a support worker from CSFS and her Band. In addition, she reported that the hospital social worker was present at the birth of her baby and was a good support. Veronica had an additional support worker in her hospital room at the birth of her child. She stated, "having my worker there to keep me cool-headed was good, it's just like I would not have been so friendly if I had no other support."

Amy shared a similar experience to Veronica—she stated that the hospital social worker was in the room at the birth of her baby and she benefited from the support and advocacy that was offered.

Amethyst had a family preservation worker from CSFS who supported her and helped her to attend appointments when she resided in her community. However, when Amethyst relocated to Prince George, British Columbia, she had no support or an advocate. As a result, it was difficult for her to get support when her children were in foster care. However, she said, "I had a worker from Carrier Sekani, and she came in [the hospital room], and she was there to support me, and she tried."

Identity and Culture

The seventh central theme that emerged from the data encompassed information regarding intergenerational trauma, identity, and culture. Four out of the five participants appeared to lack a connection to identity and culture, had limited contact with their communities, and had limited knowledge regarding the history of MCFD with Indigenous children, families, and communities. The exception was one participant, Butterfly Babe.

Butterfly Babe grew up in her community with her grandmother and remained connected to her family, identity, and culture. She was the only participant who felt that MCFD targeted her as an Indigenous woman. Butterfly Babe described being unable to reside with her mother and was raised by a family member when she was a child. She believed that "they [MCFD] bring down Aboriginal people like we, we don't really look after children very good, bring up other family member's history, history can go into you're a drunk and an alcoholic" and "MCFD told me that was the way my mom has been they think, I'm gonna be that way too kind of thing you know." Butterfly Babe stated:

> Well, I feel like they [MCFD] just do that [bring children into care] to Aboriginals because the get money off of us and we are that to them is just, I don't see any other kids that are in care, don't see any other kids in care, they just that we are easy and same with the foster parents, make a lot more money for foster kids than and you know they don't really use that money for the children.

Veronica's situation was very different. Veronica was adopted into a Caucasian home and when asked how she felt as an Indigenous woman, Veronica reported,

> I'm actually not too sure like how I felt like I never really feel like that because I was raised in a very white family so it's just like I had no cultural background knowledge, like I never been to my home that often since I was removed and it's just like up until now I've had no cultural um connection so it's just like now I'm discovering and I'm being able to go back home to be able to learn just as much as my children do along the way like it's a very positive and just like I find that like there was quite a bit I missed out on.

Veronica was placed with her biological siblings, but she had little connection to her community and culture. Veronica had dealt with trauma most of her life growing up in foster care and being adopted, and did not want to pass that on to her children. Veronica's biological father passed away which was difficult for her. It was compounded by the fact that she was unable to discuss her feelings of grief and loss with her adoptive family. Veronica stated, "but I also get that feeling that I'm not their [adoptive parents] child, so why do your problems matter to me kind of thing." At the follow-up interview, she discussed her memories of her early childhood, while with her biological family, and not being hugged, kissed, or played with before she was removed and placed into care. Veronica disclosed she

had no desire to play with her children and that she struggled with her childhood trauma and how it affected her parenting. She said that she wants to "break the cycle of emotional neglect." Recently, Veronica discussed going back to her community and she started to reconnect with her identity and culture. She connected with an uncle who was supportive and healthy from her paternal side of her family—which she described as a positive connection.

Janita was raised in non-Indigenous foster homes; while her biological siblings were placed together in another foster home; she never resided with her siblings. Janita entered foster care when she was nine years old. She stated that her mother voluntarily placed her in care. Between the ages of nine and 18, Janita had lived in "28 different foster homes," most of them non-Indigenous. Janita described that she was never taught about her culture and that she struggled to identify herself in relation to her Indigenous culture. She also indicated that biologically she was half Indigenous and does not know much about her Indigenous side of her family—other than that they were unhealthy and drank alcohol. Janita discussed that her mother had an alcohol addiction and that she had to call the ambulance on her when Janita was pregnant with her first child. Janita felt that her family and people from her Indigenous community are "too much into their drinking and drugs."

During her interview, Amy discussed her feelings regarding when MCFD arrived in her hospital room at the birth of her baby. Amy stated, "that kind of thing wouldn't have happened like 50 years ago, right?" This comment generated a conversation regarding the Sixties Scoop and residential schools. Amy was not aware of either events. Amy did not discuss culture or identity during the interview, but mentioned that she had access to more supports as an Indigenous woman.

Amethyst reported that she had spent time living in her community as an adult. Amethyst and her children "are going twice a month back to the reserve for Elders group, or the Elder's Feast." When asked if she grew up doing cultural activities, Amethyst remembered, "Kind of with my grandmother, I learned how to do moccasins and beading ya." While Amethyst has a connection to her community, culture, and family, there still appeared to be a disconnect regarding how or if being Indigenous impacted MCFD involvement. Amethyst did discuss feeling that living in her community caused her to be called into MCFD more frequently for concerns that were not legitimate.

Bonding

The eighth and final central theme which emerged from the data was bonding. The bond discussed in this central theme was in relation to the emotional connectedness between the mothers and their child.

All the mothers except for one had their infants with them during the participant interviews. This allowed me to observe, firsthand, the love, attentiveness, and bond the mothers shared with their infants. The infants and mothers appeared to have a strong bond. Each mother read and attended to her baby's cues which resulted in the baby being held, fed, changed, or prepared for a nap by the mother. During the interview with Veronica, there was a five-minute break where she fed and changed her infant. The mothers talked to their babies during the interviews and spoke in a positive manner about the infants. They described their babies as "happy," "smart," "handsome," and "good." The babies responded by smiling at their mothers, making eye contact and babbling, as well as reaching to them for comfort. This demonstrated the emotional bond and connection which was evident between the mothers and their babies.

Amethyst was not able to keep her baby at birth and described yearning for the bond which she and her baby were never able to share. When her child was removed from her care, Amethyst remembered that she felt hopeless, which resulted in the creation of a downward spiral—which she described ended when she "hit rock bottom." Amethyst discussed rock bottom as being homeless, using drugs, and not having any contact with her children. During my two follow-up interviews which were with participants who had not had their children removed at birth, I asked the mothers how they believed they would have reacted if their children had been removed. Both mothers stated they would have spiralled downward and continued in their addictions. They both stated that they would do anything for their children.

One of the mothers described that she was robbed of the ability to breastfeed and to bond with her child when her child was removed at birth. Another mother felt that MCFD had intruded on her ability to bond with her infant by the way of not supporting her wishes to breastfeed and to support the father to get the child in his care. Both mothers who had their children removed at birth felt that they lost the ability to build an immediate bond with their children. The mothers discussed feeling angry, lost and frustrated when they were not able to bond with their children in the way they wanted to.

Conclusion

Eight central themes and nine subthemes emerged from the analysis of five face to face interviews with Indigenous women. These themes and subthemes were: (1) the impact of child welfare involvement (including subthemes powerful emotions, trust, communication, and dismantled families); (2) a structural power imbalance (feeling powerless, being watched and judged, and jumping through hoops); (3) addictions; (4) socioeconomic struggles (young

mothers and poverty, homelessness and neglect); (5) missed preventative opportunities; (6) the role of advocacy; (7) identity and culture; and (8) bonding. The data reflected the voices of the Indigenous women who acknowledged their experiences with the child welfare system at the birth of their child or children. The mothers provided insight into their involvement with MCFD in relation to the emotional impact of MCFD and the power imbalance experienced. The mothers articulated the importance of advocates and the need for communication and collaboration.

Chapter Five: Discussion

This is the first research project, to my knowledge, which examines the experiences of Indigenous women with MCFD at the birth of their baby. The data collected and discussed in the findings chapter demonstrated the impact of MCFD involvement, the structural power imbalance of MCFD, addiction and socioeconomic struggles of the Indigenous mothers, the impact of preventative practice and advocacy, identity and culture, and bonding during the time of pregnancy and at birth. Reflection on Chapter 2 of this thesis illustrates that current literature touches on different aspects of my research findings. This chapter provides insight into the data collected, provides a context to the importance of the findings and described how the data relates to, and can improve, social work practice. This discussion chapter contains eight headings and two sub-headings as follows: (1) the responsibility of MCFD (communication, collaboration, and prevention; advocacy); (2) bonding; (3) moving towards a brighter future; (4) identity and culture; (5) implications for policy and practice; (6) dissemination; (7) areas for future research; and (8) conclusion.

The Responsibility of MCFD

It was clear from the findings that the mothers needed support and assistance from MCFD, but were reluctant to request it as they feared the removal of their baby at birth. Most of the mothers struggled during pregnancy with a number of challenges. For example, they had other children placed in foster care, they were homeless, living in poverty, and were dealing with their addictions. Between the fear of the removal of their baby and being overwhelmed with the other struggles, it is clear why the participants did not seek support from MCFD. I developed themes from the findings that may be insightful for child protection social workers who are working with Indigenous mothers. Communication, collaboration,

and prevention, and advocacy were identified as important components to examine when working with these Indigenous mothers. The below section examines the role communication, collaboration and prevention played between the relationship with MCFD and the participants.

Communication, collaboration, and prevention. Communication, collaboration, and prevention were important themes which emerged from the data. The mothers described their frustration, anger and complacency when the social workers spoke to them in an abrupt and rude manner. The mothers' narratives highlighted that MCFD social workers did not actively engage with them and did not connect or collaborate with them to work in a preventative manner.

One mother discussed that MCFD contacted her twice during her pregnancy before her phone was no longer in service. I have witnessed situations where MCFD often placed the responsibility on the parent to establish and continue the connection with their child protection social worker. It is a social worker's responsibility to ensure families are supported and this means making all attempts to engage and connect with families in order to offer support and mitigate risk. This action may create a collaborative and trusting relationship, which has the potential to generate change in the mother's addiction which in turn has a positive impact on her infant. This mother discussed that she used drugs during her pregnancy because she believed she could not quit as the drugs were helping her deal with a medical issue. This issue was not diagnosed until her child was born. The first step MCFD completed via a phone call was a positive action, however, once her phone was out of service, it appeared that MCFD made no further attempts to connect with the mother. The

mothers appreciated when their social workers made an effort and offered support in a positive, and courteous manner.

Parents involved with MCFD are often dealing with a number of social issues such as an addiction, homelessness, and poverty as noted in the findings. Social workers obtain an education that equips them to interact with various individuals in need. Child protection social workers have a strong understanding of the child welfare legislation and MCFD's practice standards. This knowledge needs to be put into practice to support families prior to Indigenous mothers giving birth. As observed in my research, four of the mothers were met at the hospital by a social worker at the birth of their child.

MCFD was aware that some of the participants were pregnant, and a safety plan was not developed with the mothers regarding the care of the infant at birth. When a plan is made prior to the birth of a child, in my professional experience, it is a much more collaborative process which facilitates trust and a potential increased positive outcome for mother and child. Cram et al. (2006) discussed the removal of Indigenous children being avoided if preventative supports are provided and preventative work is done. Preventative work is often pushed off to the side due to MCFD workers having too many families to serve and being driven by emergencies (Rousseau, 2015, 2018). According to my findings, coupled with the academic literature and my professional experience—the child welfare system appears broken, in particular, when serving Indigenous mothers and children during pregnancy and at birth.

A majority of the mothers in my study were able to keep their children due to a local supportive housing program. In addition, the mothers implemented many personal changes and completed challenging work in order to care for their children. Their situation did not

transpire from MCFD creating a preventative safety plan with the mothers. When preventative work is completed during pregnancy, a plan is put in place for the mother, expectations from all parties are shared, and the birth experience at the hospital does not involve MCFD. Creating inclusive plans for mothers and their children can be very powerful, especially if the band, family, and advocates are involved (Rousseau, 2015).

Prior to September 16, 2019, MCFD sent birth alerts to the hospital if there were foreseen child protection concerns regarding a pregnant mother. MCFD sent a memo to the hospital and was entitled to be notified when the baby was born (Wall-Wieler et al., 2017). The mothers I interviewed believed they were recipients of birth alerts, as all of the mothers had MCFD social workers attend their hospital room at birth. Birth alerts are no longer occurring in practice; however, the timing of this shift did not benefit the mothers in my study, as they were affected by the birth alert policy. I believe that the demise of birth alerts, is a positive practice shift for the child welfare system.

MCFD social workers should treat people with respect, support and not blame mothers, and view the family as a unit, exploring what the family and Indigenous community may want for their family. Is it possible that MCFD as a system lacks the understanding regarding the implications Western, oppressive systems have had on Indigenous people and are insensitive to the needs of Indigenous mothers? Rousseau (2015, 2018) discussed MCFD workers as being prejudiced and racist, often waiting for Indigenous families to fail. Unfortunately, I overheard an MCFD team leader say, “Once we get this order, it is up to the mother to decide to get support and ask MCFD for support.” It is within the BC code of ethics for social workers that all “social workers shall maintain the best interest of the client as the primary professional obligation (British Columbia Association of Social Workers,

n.p)", especially Indigenous women who face the impacts of colonization, including residential school, and the sixties scoop, which resulted in intergenerational trauma, substance use, addictions, poverty and homelessness (Cull, 2006; Ing, 2006; Reid et al., 2008; Shahram et al., 2017; Varcoe et al., 2013). Social workers are agents of change who should be motivated at any possible cost to foster change for individuals in need.

It is unrealistic to assume, that the mothers in need of services are well enough to contact MCFD to solicit support, as they are often struggling with addictions due to historical practices It is my belief that outreach to these vulnerable women relies on the skill set of the professional social worker to engage the client in meaningful, productive services. Voluntary services can be offered to pregnant Indigenous women, and information sharing among supports and advocates are supported by MCFD in attempts to improve outcomes for Indigenous women and children.

It is important to note that some of the mothers mentioned they had a good relationship with their social workers at MCFD. These social workers appeared to be collaborative and supportive, and they stayed in regular contact with the mothers, which demonstrated a caring and supportive approach. The mothers who could not reach their social workers had negative feelings towards them and MCFD as a system.

The data analysis strongly suggested MCFD social workers need to take the initiative and reach out to Indigenous mothers during pregnancy, in order to create a safety plan which would in turn, foster trust and collaboration upon the birth of the baby. This collaboration and trust would positively influence outcomes for Indigenous women and children. If MCFD social workers are unable to connect with the Indigenous woman after exhausting all attempts, the findings emphasized the importance of appropriate language and tone that

ought to be used when arriving at the hospital at birth. The mothers felt powerless and felt the MCFD social workers were blaming the women for their circumstances, and apparently this message was echoed in an abrupt and rude manner which added to a sense of inferiority.

Advocacy. The participants highlighted the importance of advocacy during the interviews. A majority of the mothers believed that their advocate was instrumental in them keeping their infant. This was accomplished because the support workers act as a buffer between themselves and MCFD. Some mothers felt it was the only way they were able to maintain care of their child. As a social worker within a delegated agency, there were times I acted as a buffer for families who appeared to be more willing to work with me than their assigned MCFD social worker. I have often relayed information between families and MCFD social workers in order to support the family appropriately. My finding concurs with Rousseau (2018) who stated that "participants reported ministry policy as a key area where insufficient engagement of Indigenous professionals, advocacy organizations, or service recipients occurs (p. 8). Given the importance that the mothers placed upon support workers and their advocates, there were still a few mothers who appeared to lack the knowledge on how to contact an advocate. One practice consideration that may strengthen outcomes for Indigenous women and children is to connect families with an advocate once MCFD begins service delivery with the family.

The mothers were clear regarding their feelings towards MCFD social workers and provided insight into how their relationship could improve. They felt that MCFD needs to make all possible attempts to connect with pregnant women and mothers, in order to create trust and to develop supportive plans prior to the birth of an infant. If MCFD receives a report about a mother's newborn infant, then all efforts need to be made to work

collaboratively and respectfully with the mother to create a safety plan. Consistent and quality communication with Indigenous women is important. As noted from the data, it facilitates trust and it is what the mothers want, which results in a better outcome for the mother and child.

Bonding

Bonding was a large focus of my literature review that explored the importance of keeping mothers and babies together at birth. The ability of the participant to articulate bonding or identify the concept of bonding was, for the most part, described in terms of actions. Two mothers used the specific word bonding that described their emotional connectedness with their child. The other mothers described or demonstrated different aspects of bonding via the way of actions which was observed during the interviews.

The mothers in this research described a strong emotional desire to keep their children in their care at birth. They indicated that they were willing to do anything that MCFD social workers requested, in order to keep their child in their care. They were willing to follow strict rules and stay in a supportive housing program, and agreed to attend all programs and supports that were put in place by MCFD, in order to mitigate risk to their child. As such, Shahram et al. (2017) believed that a bond should be considered of utmost importance at birth while still maintaining child safety. The strength of the mother-child bond was demonstrated when two of the mothers stopped the use of drugs and alcohol once they gave birth. The other women made positive changes during their pregnancies in attempts to modify their substance misuse. This emotional desire for mothers to keep their children is important to foster for the benefit of both mother and child (de Cock et al., 2016; Edwards et al., 2017; Figueiredo et al., 2009; Redshaw & Martin, 2013; Rossen et al., 2016). It is

important to note, that none of the mothers were using or drinking at the time of the interviews. My findings align with Shahram et al. (2017) and Reid et al. (2008) who discussed that keeping women and children together at birth and promoting bonding can help reduce mothers' drug and alcohol use.

One mother had her child removed at birth which resulted in a downhill spiral of substance use and homelessness. Her situation is in line with research conducted by Wall-Wieler et al. (2018), who stated that removals at birth interrupt the bond in mothers and their infants and often results in mental health difficulties and substance use for mothers and can result in aggression and trauma in children. Some of the participants had their child present during the interviews, as noted in the previous chapter. I witnessed the love and emotional connectedness between mother and child. Newman et al. (2015) discussed that babies who are born with Neonatal Abstinence Syndrome (NAS) and are able to bond with their mothers are more likely to require less medical intervention and less likely to be removed. Another important factor supporting the mothers to parent their children was the ability to have supportive housing in Prince George, which maximized the opportunity for mothers to keep their infants when removal would have previously been the only option.

It is essential for child protection social workers to be educated regarding the negative implications a removal at birth can have on infants and mothers long-term, and weigh that against the safety of the infant. Sometimes removals cannot be avoided, but whenever possible, MCFD social workers need to exhaust every opportunity to keep mother and baby together. Recognizing that there are situations where mother and baby cannot be together despite the execution of all measures, I hope to use the finding from this research to create and inform supportive parenting programs in Northern British Columbia. In particular,

programs that aim to foster the bond between mothers and infants, in order to support their emotional connectedness.

Overall, the importance of bonding was witnessed in this research. The value of bonding should be considered during pregnancy and at birth, and MCFD must make all attempts to keep mothers and babies together while keeping babies safe. In the next section, I discuss the services available to mothers in Prince George, and other programs offered elsewhere that could benefit Indigenous mothers and promote bonding.

Moving Towards a Brighter Future

There are many concerns regarding the child welfare system, as outlined in Chapter 4; however, MCFD has also implemented positive steps in the right direction. While the positive changes were implemented following the women I interviewed, I believe it is important to discuss them, as they address some of the gaps in service and policy.

In January 2017, a lady named Maria Brouwer opened supportive housing for expectant and new mothers needing support and involved with MCFD. I do not have the statistics on how many women have gone through Harmony House since that time, but I am aware this home has offered an alternative to removal. I have a professional relationship with Maria and worked with Harmony House in my professional practice. While Harmony House is not a fit for everyone's needs, it provides mothers a chance to keep their babies and to bond with them. Harmony House offers a safe, supportive, fully staffed resource, and MCFD often agrees that Harmony House is suitable for many mothers instead of a removal. Harmony House has given pregnant women and mothers, many Indigenous, both in Prince George and many in outlying communities, an alternative to removal at birth.

Harmony House is a wonderful program, but there are still Indigenous women and mothers falling through the cracks, much like one of the mothers in this research. The model of Fir Square at BC Women's Hospital and Health Centre as previously discussed—is a model that would add another layer of support. Fir Square is the only one of its type in British Columbia and is described as a rooming-in program that allows babies with NAS to stay in a room with their mom while they detox (Newman et al., 2015). The rooming-in model allows mothers to stay with their babies in a non-judgmental, culturally sensitive environment where mothers and babies can bond and decreases the likelihood of a removal. This program is greatly needed in Prince George, and I hope that this type of program comes to fruition one day soon.

The long-standing birth alert policy practised by child welfare organizations, including MCFD, finally ended on September 16, 2019. As an employee of NBHCFSS, I received training on the new policy regarding the termination of birth alerts. As of the end of September 2019, MCFD was no longer allowed to send letters to the hospital, even if they were concerned about a mother's alcohol consumption or use of drugs during pregnancy. Any information obtained by MCFD during the length of a woman's pregnancy can no longer be used as part of the assessment upon the baby's birth. The premise of the policy change is to encourage child protection social workers to engage with expectant mothers in a voluntarily capacity, in order to support them and offer an array of preventative services. The social workers should engage the parent and the applicable Indigenous community with their consent in pre-birth planning (MCFD, 2019). This shift in practice is congruent with a finding in my research which was captured under the theme of advocacy. Much of the support the Indigenous women received by way of an advocate was conducted in a culturally

appropriate and respectful way. MCFD's relatively new policy supports women to make changes during their pregnancy without the women worrying that if she relapses, it may result in the removal of her child at birth. Another positive outcome is that women and mothers can reach out for support from MCFD and the information collected cannot be used against them once their child is born. This policy will hopefully remove the fear many of the participants described when they were pregnant and faced with MCFD involvement. Reaching out for support will hopefully be viewed as a strength and not result in a removal. In sum, the opening of Harmony House and the eradication of the birth alerts are positive actions that move the practice in a positive direction for Indigenous mothers and children.

The Role of Identity and Culture

I work solely with Indigenous women, children, and families in my professional practice and most of these Indigenous peoples have connection to their community and culture. On many occasions Indigenous families reported that the only reason MCFD was involved in their lives was due to the fact that they were Indigenous. I work with many Indigenous people who understand the history of colonization, residential school, the Sixties Scoop, and the devastation these things caused Indigenous communities (Cull, 2006; McKenzie et al., 2016; Rousseau, 2015, 2018; Trocme et al., 2004). I went into this research with the assumption that the participants would be rooted in their culture and understand the relationship Indigenous people often have with the child welfare system, specifically MCFD, based on my professional experience as a social worker along with the well documented literature. Reading and reflecting on my journal entries illustrated that the mothers involved in my research did not appear to recognize the impact that colonization, the Sixties Scoop,

and residential school had on Indigenous lives. As noted in the findings, the theme of identity and culture emerged from the data and is discussed in further detail.

There were many pieces of information from the interviews which touch on colonization, intergenerational trauma, the Sixties Scoop, and residential schools, although most of the participants did not appear to connect their experiences with these factors. I tread cautiously and recognize that as a non-Indigenous researcher, I cannot speak for Indigenous mothers and do not want to misinterpret the research findings, in particular misunderstanding their sense of identity and culture. The data from the participants, coupled with the literature and my professional experience, are explored further below.

Many of the women I work with professionally spent time in foster care as young children and some were adopted into Caucasian homes. This was true for some of the participants in my research study. Choate et al. (2019) stated, "when we consider the IRS [Indian Residential School], the Sixties Scoop, and the continued over-representation of Indigenous children in care, there is little doubt that trauma has been imposed upon Indigenous families for several generations" (p. 65). While most of the participants were not able to verbally describe the impact or the link to colonization, from my perspective there were clear signs the participants were impacted by colonization—their life experiences and lifestyles were indicative of such historical practices. The extensive academic literature discusses the impacts of colonization, residential school, and the Sixties Scoop continue to have on Indigenous populations, including intergenerational trauma, poverty, a lack of parenting skills, the large number of Indigenous children in care, loss of language, loss of culture, and increase of alcohol and drug use, domestic violence, and neglect (Aguiar & Halseth, 2015; Bennett, 2008, 2009; Choate et al., 2019; Cull, 2006; Evans-Campbell, 2008;

McKenzie et al., 2016; Niccols et al., 2009; O'Donnell et al., 2010; Rousseau, 2018; Shahram et al., 2017; Trocme et al., 2004; Varcoe et al., 2013). Many of the participants had a number of risk factors identified in the above literature. For example, one of the mothers discussed that she was half Indigenous and grew up in foster care from the age of nine due to her mother's alcohol addiction. She lived in 28 foster homes between the ages of nine and 18, until she was eligible for independent living—one of MCFD's youth programs. Her two children were placed in foster care. This mother's story followed a common path that many Indigenous women experience as a result of colonization, residential school, and the Sixties Scoop as well as, poverty, addiction, loss of culture, lack of parenting skills, and being raised in foster care. On one hand the participants were unable to articulate the impact of colonization; however, based on their personal stories they were living the impact of intergenerational trauma.

Some of the mothers in my research were not raised by their biological parents, one was placed with a biological family member, and one was adopted into a Caucasian home and firmly discussed feeling "white" on the inside, regardless of what she looked like on the outside. Choate et al. (2019) discussed the structural issues with adoption, as there is no way to hold adoptive parents accountable to ensure they are exposing Indigenous children to their culture. Culture plans created through MCFD or DAAs are designed to ensure adoptive parents will bring children back to their communities, but these are goodwill agreements and are not court enforceable (Choate et al., 2019). As part of my role at NBHCFSS, I collaborate with management and co-workers to ensure children are returned to their community's numerous times a year to create and continue a cultural connection. The children with their families are exposed to the community or communities they belong to, and learn the

language, and cultural teachings specific to each child. However, as Choate et al. (2019) described, any cultural safety agreements for adoption and permanent plans are not court enforceable and some of these children have no connection to community or culture. Some of the women started to learn about their culture at their current residence and participated in cultural activities, which included returning to their community. The women discussed introducing their children to their Indigenous culture and learning alongside them, and they described this as a positive experience. Choate et al. (2019) discussed that not all Indigenous communities allow residential schools, the Sixties Scoop, and colonization to define them and are taking their power back by providing cultural supports, resources, and opportunities. The positive experiences the women described participating in their culture and returning to their communities demonstrated that they and their children have started a journey to learn about the history of their peoples. I contemplated what the outcome would have been if these mothers had been involved with their culture for their entire lives. Would it have made a difference to their current circumstances?

The academic research claims that the child welfare system has unevenly targeted Indigenous women, children, and families, which has resulted in a high number of Indigenous children in care (Cull, 2006; Ing, 2006; McKenzie et al., 2016; Rousseau 2015, 2018). The mothers who participated in this research did not appear to acknowledge the link between the two; however, each of the mothers discussed feeling fear and anger regarding their involvement with MCFD. When asked how they felt about being Indigenous and their involvement with MCFD, the majority of the participants did not answer the question. Four of the mothers were not aware that their ancestry had an impact on MCFD involvement. Only one participant discussed that she felt that MCFD wanted to steal “Aboriginal babies.” As

noted above, I heard this statement numerous times, resulting in my assumption that the majority of the participants held this view regarding MCFD. I kept asking myself why there was such a disparity between my professional experience with Indigenous families, the academic literature, and the results of my research. In response, colonization was the act of assimilating Indigenous peoples into Western society, and residential schools were developed to remove the "Indian" from the child (Cull, 2006; Ing, 2006; McKenzie et al., 2016; Rousseau 2015, 2018). This has resulted in intergenerational trauma and the large number of Indigenous children in foster care in B.C. While my intent was not to make assumptions regarding the views of the participants, the literature, combined with the life experiences of the mothers, illustrated that each of these Indigenous mothers had been impacted in some capacity by colonization, residential school, the Sixties Scoop, and/or intergenerational trauma, even if they were not able to vocalize or link their experiences to past atrocities.

Cull (2006) indicated that an Indigenous woman, especially one who lives in poverty, is considered one of the most disadvantaged groups in Canada. Adding to this, Varcoe et al. (2013) argued that many Indigenous mothers face adverse birth outcomes as they are impacted by low socioeconomic status, racism, cultural loss, trauma, and exposure to violence. Research by Cull (2006) and Varcoe et al. (2013) aligned with the participants in my research. The mothers all struggled with either homelessness or poverty. One mother's children were removed due to neglect, which is often directly related to poverty (Carriere & Richardson, 2009; Torchella et al., 2014). Three of the mothers were homeless during their pregnancies, and one participant discussed not having food but ensured that she fed her baby, even if she went without. Niccols et al. (2016) discussed young mothers being at a higher socioeconomic disadvantage and that Indigenous women often become mothers at a younger

age. This appeared to be a pattern in my research, as three of the mothers had their first born at the age of 16. The impacts of socioeconomic disparity these Indigenous mothers faced can be traced back to the impacts of colonization, residential school, and the Sixties Scoop.

All child protection social workers need to understand the history of colonization, residential school, the Sixties Scoop, intergenerational trauma, and the socioeconomic struggles and structural power imbalance Indigenous women and mothers face. This understanding can assist social workers in the creation of safe and culturally appropriate practice which builds capacity with Indigenous women and families. The findings reflected some positive practice between mothers and MCFD, which is encouraging. However, a culturally sensitive approach is fundamental in order to create positive working relationships with Indigenous women, mothers, and children. While it may not be essential for these women and mothers to understand colonization, residential school, and the Sixties Scoop, child protection social workers need to understand the impact and practice accordingly. In the next section I discuss how my research findings can influence policy and practice.

Implications for Policy and Practice

The mothers described that, having positive and regular communication with their social workers (MCFD), would empower them to plan for their child and to stand up for themselves without being punished. Many of the women described a distrust of MCFD, as communication appeared to be lost, and they felt that MCFD had all the power in terms of decision-making. When communicating with Indigenous women and mothers, it is important for child protection social workers to remember the social-historical impact of colonization, residential school, and the Sixties Scoop.

A major theme that emerged from the data was the importance of an advocate for Indigenous women when involved with MCFD. It is essential that MCFD social workers provide information on relevant support services to Indigenous women and mothers, and when possible, MCFD should connect the mothers with support services, as access to community providers may be a barrier, as observed in the findings.

The mothers provided suggestions for ways MCFD social workers can create positive relationships with Indigenous women and mothers. The most important step identified was for MCFD to take responsibility for contacting the parents and ensuring that communication is ongoing. This involves making all concerted efforts for the child protection social worker to connect with the client. The mothers want their power back so they can take responsibility for planning for their child. This would include, who they want to attend meetings and where they want to reside. The mothers noted that, they do not feel comfortable showing emotion in the presence of MCFD child protection social workers, as they feared this would be viewed in a negative manner, possibly resulting in the removal of their child. These mothers need to vent and cry to let their emotions out. They should not have to remain calm, worried that they will be reprimanded. In my professional practice, I have witnessed mothers crying and yelling, and the social worker deeming this response as inappropriate as the baby was present, and the social worker choosing to scold the mother. An alternative is to request the nurse to take the infant out of the room while the social worker communicates with the mother. Social workers in general and more specifically, child protection social workers, are used to dealing with high conflict situations and people who are displaying a continuum of emotions. Social workers should try to support the mother and ensure the child's safety. There are ways to be creative and support mothers through the

emotional process in a respectful and sensitive way. While the child's safety is paramount, the participants discussed that they felt overwhelmed with emotion. This is expected given there are several factors at play—the mother gave birth to her baby, met her infant for the first time, hormonal changes, followed by a visit from a child protection social worker (MCFD) who may remove her infant.

The CFCSA provides child protection social workers with steps that are required to assess a child's safety and provides different options which are available to families. There are many ways to be creative to keep mothers and children together while keeping children safe. The CFCSA provides legal obligations and timelines that child protection social workers are required to meet; there are many opportunities to provide support to Indigenous women, mothers, children and families.

In sum, the participants felt very disempowered and mistreated by their MCFD social worker(s); however, with the suggestions disclosed above, there is a possibility for more culturally sensitive and respectful practice which could improve relationships between MCFD and Indigenous mothers, improving outcomes for mothers, children and families.

Areas for Future Research

For future research, it would be positive to interview a larger number of participants, interviewing women who are not able to live with their child in supportive housing; this would create additional rich data.

I would also be interested in doing research to find out how many Indigenous women are able to keep their babies at birth, and maintaining care of them long-term. Four out of the five participants maintained the care of their children at birth. Will all four have their children in their care until they turn 19 years old, or will their children be removed? The hope

is that all the women would be able to maintain the care of their children long-term. However, if their children are removed in the future, I would be interested in finding out the reason for the removal or what support was lacking.

For future research it is important to examine the impact and role of fathers when children are removed at birth, or if there is MCFD intervention. Many of the women briefly mentioned their partners and stated they were still in a relationship, but it was unclear how the situation impacted the fathers. It would be interesting to do a similar research project but focus on the fathers instead.

Conclusion

The mothers who participated in this research discussed their experiences with MCFD in a mostly negative way, although some of the mothers were beginning to have positive, collaborative relationships with their social workers.

It was clear that MCFD places large expectations on vulnerable women who are struggling with addiction, homelessness, and poverty. MCFD should take over the responsibility of contacting families instead of making minimal efforts and telling the mothers they could not get hold of them. The mothers discussed difficulty communicating with their MCFD workers and frustration when social workers would not return their calls.

The imbalance of power was evident in the interviews, with the mothers feeling as if MCFD was letting them keep their children, or MCFD workers could come into a hospital room and apprehend a mother's child. The fear of MCFD was real for the mothers, and they felt they were unable to show emotion to their social workers. Many of the mothers also felt they could not go to MCFD for help as their child or children would be apprehended.

The sense of cultural identity appeared to be minimal for most of the women, and though they were starting to rediscover culture, the strong connection to community and culture appeared to be lacking. One mother felt her identity as an Indigenous woman was why MCFD was involved with her.

Overall, there was no discussion around the sense of bonding. However, all of the women stopped using drugs and drinking either during pregnancy or once their child was born. This shows a desire for these women to keep their children in their care.

The voices from the mothers interviewed were powerful, and they were able to discuss their experiences with MCFD at birth. In moving forward, these mothers strive to have MCFD out of their lives and are willing to do whatever is asked of them. The lack of trust, communication, and collaboration, and the imbalance of power between MCFD and Indigenous mothers need to be re-examined if positive change is going to happen.

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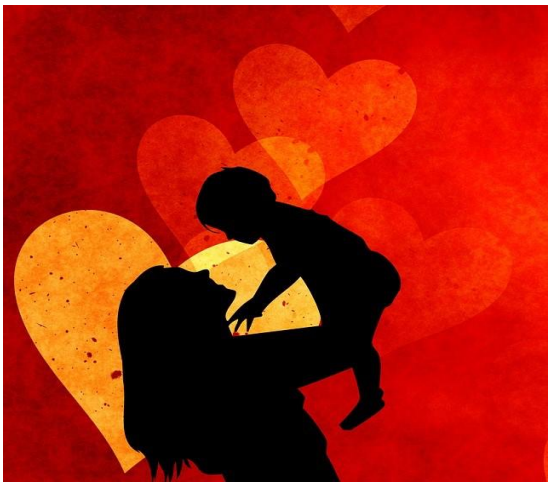
Appendices

Appendix A: Recruitment Poster

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

RESEARCH PARTICIPANTS WANTED



I am doing research to hear from Indigenous women who currently have Ministry of Children and Family Development involvement when their child or children were born, or have had involvement within the past 10 years.

Your input is very important to understand the strengths and weaknesses of the child welfare system.

ARE YOU ABLE TO PARTICIPATE IN THIS RESEARCH?

- Are you a mother?
- Are you 19 or over?
- Do you identify as Indigenous?
- Did a Ministry of Children and Family Development social worker come to the hospital when your child was born, or while you were still in the hospital?
- Is your involvement with the Ministry of Children and Family Development Current or occur within the past 10 years?

If you are interested in this research and answered yes to the above questions please contact me at 778-675-1670 or Buchner@unbc.ca to arrange a meeting to discuss your potential participation .

Each successful participant will receive a $25 gift card for Tim Hortons

Free Phones Available At:

Central Interior Native Health—1110 4th Ave.
Active Support Against Poverty—1188 6th Ave.

Free Computer Access At:

Prince George Public Library—888 Canada Games Way
Income Assistance Office—1445 10th Ave.

This study has completed the UNBC ethics review process.

Appendix B: Information Letter / Consent Form

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

Experiences of Indigenous women involved with the child welfare system at the birth of their child

1. **Who is conducting the research?**
   Student Researcher: Buchner, Katelynn, Master of Social Work Student, School of Social Work, University of Northern British Columbia, buchner@unbc.ca, phone number: 778-675-1670
   Supervisor: Dr. Tammy Pearson, Associate Professor, School of Social Work, University of Northern British Columbia, tammy.pearson@unbc.ca,
   This research is being conducted as part of the requirements for a master's of social work degree. The research will be a public document.
2. **Why are you being asked to take part in this research?**
   - You are invited to be part of this research because of your involvement with the Ministry of Child and Family Development (MCFD) when your child or children were born.
   - The involvement with MCFD can be current or could have occurred within the past ten years.
   - You are an Indigenous woman and mother.
   - This research seeks to find the strengths and weaknesses in the current child welfare system for Indigenous mothers at the time of birth.
   - This research is important as it will allow participants to discuss their experience of recently giving birth while dealing with MCFD.
   - Participation in this research is voluntary; participants can refuse to answer any question that makes them feel uncomfortable.
   - Participants have the right to withdraw from the research at any time. Any information provided up to that point will be removed and securely destroyed.
3. **What will you be asked to do?**
   - Participants will take part in a 60-90 minute interview.
   - You will be asked about your experience with MCFD during the birth of your child, and what it was like for you to have MCFD involved at that time.
4. **What are the potential risks of participating in this research?**
   - Risks could include, negative emotions, bringing up trauma, psychological difficulties.
   - If at any point during the interview you feel uncomfortable, are unable to continue, or begin to experience other negative impacts due to the research and wish to end your participation, please inform the researcher immediately and your decision will be respected.
   - If you decline to continue with the research, any information collected up to that point will be destroyed immediately in a secure way.

- While there will be questions asked, you have the option to answer as much or as little of the question as you wish and are able to skip the question all together.
    - **The following are support services available in the community of Prince George, if participants need support:**
        - **Brazzoni & Associates:** 301-1705 3rd Avenue, Prince George, 250-614-2261. This service is free to most Indigenous peoples living in Prince George.
        - **Native Friendship Center – Healing Center:** 3rd floor – 1600 3rd Ave Prince George, 250-564-4324. This is a free service and has drop in counselling appointments.
        - **Health and Wellness Counseling Program – Carrier Sekani Family Services:** 987 4th Avenue, Prince George, 250-692-2387. This is a free service.
        - **Community Care Center: #206, 1811 Victoria Street**, Prince George, 250-562-6690. This service is free.
        - **Northern BC 24 Hour Crisis Line:** 250-562-1214 (or toll-free at 1-888-562-1214 if outside Prince George). This is a free 24-hour service, 7 days a week, 365 days a year. There is an online chat available as well through www.northernyouthonline.ca
        - **FOUNDRY:** 1148 7th Avenue, Prince George, 250-423-1571. This is a free, drop-in service for people aged 12-24 years.
        - **Central Interior Native Health Society:** 1110 4th Avenue, Prince George, 250-564-4422. This is a free service to all Indigenous people.
        - **University of Northern British Columbia Hospital:** 1475 Edmonton Street, Prince George, 250-565-2000 (during business hours). For immediate assistance contact an ambulance by dialing 911 at any hour. Free service.
        - **Wellness Center – University of Northern British Columbia:** 3333 University Way, Prince George, 250-960-6369. There is a fee for this service sometimes, call to find out if you are eligible for free counselling.

5. **<u>What are the benefits of participating?</u>**
    - If you choose to participate in this research, you will be able to share your experience of having MCFD involvement when your child was born. You will be able to provide your insight into how the child welfare system effects Indigenous women. This will guide social workers and other support workers to assist Indigenous women and their infants in a more positive and culturally safe way.
6. **<u>How will we maintain your confidentiality?</u>**
    - The interview will be audio recorded.
    - Your privacy is our highest priority. No personal information will be released without prior consent from you, unless it is required by law, or there is disclosure of harm to self or others.

- We will use a pseudonym to protect your identity in all documentation and in the final thesis. This pseudonym will be agreed upon by researcher and participant.
- All information collected by audio recording will be kept in a locked safe. All written information will be kept on a personal password protected computer.
- Only the researcher and their supervisor will have access to the audio recordings.
- The audio recordings and any written information that relates to the interview will primarily be used for this research but may also be used for future research and/or presentations. In consultation with my academic supervisor my goal is to present my findings to the child protection teams in the Prince George area, present my findings at an international conference which is being held next July 2020 in Calgary, Alberta (International Conference of Social Work), and I plan to write an article and submit for publication with my academic supervisor and committee members.
- Research participants are entitled to receive a copy of their transcribed interview. If requested, hard copies will be delivered by to the participant personally by the researcher.
- If requested, the interviewer will send an electronic copy to the participant, the electronic copy will be password protected to ensure only the participant can open the document. The password will be agreed upon by the researcher and participant at the first interview.
- The participant can request a follow up interview to discuss the information gathered in the first interview, or the findings of the research once it is completed. At the follow up interview the participant can ask questions about the initial interview. The follow up interview will be held at a location decided upon by participant and researcher. Confidentiality will be kept in mind as sensitive information will be discussed.
- Interviews may occur in the participant's home; it is important to note the researcher does not have control over privacy in the participant's home. The researcher will ask the participant who is in the home during the interview and explain that the topic may trigger one or more persons in the home. The researcher will encourage the participant to meet in a private area of the home where the conversation will not be overheard.
- The participant may request to have a support person with them during any interviews. Confidentiality will be discussed with the support person, and verbal confirmation on the audio recording will be required by the participant to move forward with the interview. The support person will be required to sign a confidentiality and non-disclosure agreement. Confidentiality with the support person can only be encouraged not guaranteed.
- Ten years after the research has been completed, the audio recordings will be destroyed. The paper documents will be shredded, and all digital files will be deleted.

7. **Will you be paid for this research?**
    - Each participant will receive a $25.00 Tim Hortons gift card honorarium as an appreciation for participating in the research. These gift cards will be self-funded by the researcher**.**
8. **Research Results.**
    - The information collected during this research project will be presented in a graduate thesis, which is a public document. It is possible this thesis could be used in future research or published in journal articles and books. At the end of this research there will be a public presentation of the research findings.
9. **Who can you contact if you have questions about this research?**
    - If you have questions about this research or your participation in this research, please contact either the student researcher or the student supervisor. The contact information is listed at the beginning of this information letter and consent form.
10. **Who can you contact if you have concerns or complaints about this research?**
    - It is your right as a research participant to relay any concerns or complaints which may come up during the interview(s) or research to the University of Northern British Columbia Office of Research at 250-960-6735 or by email at reb@unbc.ca

Consent Form

Participation in this research is completely voluntary. I understand that by agreeing to participate in this project, I may withdraw from the project at any time up until the report is completed, with no consequences of any kind.

I have read or been described the information presented in the information letter about the project:

YES **NO**

I have had the opportunity to ask questions about my involvement in this project and to receive additional details I requested.

YES **NO**

I wish to have a support person with me during the interview.

YES **NO**

I agree to be recorded

YES **NO**

I understand that the researcher's sole purpose is to collect information and not to act as a social worker or support person. Information for support services has been given at the beginning of this document.

YES **NO**

I understand I have the right to withdraw from the research at any time. Any information provided up to that point will be removed and securely destroyed

Participant Signature _____

Printed Name of Participant _____

Date (Day/Month/Year) _____

Appendix C: Questionnaire

1. When did your involvement with MCFD begin?
2. What do you believe began your involvement with MCFD?
3. How far along were you in your pregnancy, or how old was your infant when you had contact with MCFD?
4. What were your positive experiences during this time?
5. What were your negative experiences during this time?
6. What was the outcome of your involvement with MCFD?
7. What would you change about your experience?
8. What supports were you offered?
9. How did you feel when an MCFD social worker showed up when your baby was born?
10. As an Indigenous woman, can you discuss your experience during pregnancy and after birth with MCFD and other service providers?

Appendix C: Consent Letter – Harmony House

Maria Brouwer
Harmony House
1765 11th Ave
Prince George BC
November 09 2018

To whom it may concern:

Re Kaitlynn Buchner

This note concerns Kaitlynn's request to interview residents at Harmony House as part of her thesis, dealing with womens' experience of giving birth and the effect Ministry of Children and Family Development's (MCFD) involvement had on their and baby's well being.

Harmony House is a safe supportive house for pregnant women and women who have just given birth, are struggling with mental health and/or problematic substance use and are in peril of loosing their children to the care of MCFD. If we get involved after the babies are removed, we work to get them back into the care of the mother. Ninety percent of our residents identify as Indigenous.

Harmony House opened on Jan 02, 2017. We have had thirty-four mothers go through our program, and all except one left with the children in their care. Of the thirty-three mothers, three mothers lost their children to care after six to twenty-four months post discharge from Harmony House. Our success rate is ninety three percent.

Part of their success is linking up with other service providers such as Nezul Be Hunuyeh Child and Family Services. Kaitlynn is a great advocate for our shared residents and I gladly offer her the opportunity to ask our residents to tell their stories as it relates to the Ministry of Children and Family Development.

I look forward to your response as to the formalities involved to complete Kaitlynn's thesis.

Sincerely,

Maria Brouwer RN BScN

Coordinator Harmony House 236 423 3335

Appendix D: Confidentiality and Non-Disclosure Agreement

This study, Experiences of Indigenous Mothers with the Child Welfare System at the Birth of their Child, is being undertaken by primary researcher, Katelynn Buchner, at the University of Northern British Columbia (UNBC).

Data from this study will be used to complete a master's thesis.

I, _____, agree as follows:

1. As a support person, I am solely here to ensure the participant has support during the interview, and if needed, a person to debrief with afterwards.

2. Any information shared during the interview, or directly related to the interview, is completely confidential and will not be shared, in any format, with anyone other than the participant and the researcher

3. I will not answer questions for the participant.

Support Person

_____	_____	_____
(Print name)	(Signature)	(Date)

Researcher

_____	_____	_____
(Print name)	(Signature)	(Date)

If you have any questions or concerns about this study, please contact:

Dr. Tammy Pearson
Associate Professor, School of Social Work
University of Northern British Columbia
Email: Tammy.Pearson@unbc.ca