

THE SOCIAL CONSTRUCTION OF SUBSTANCE USING WOMEN IN BC'S CHILD
WELFARE SYSTEM

by

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A GRADUATING ESSAY SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SOCIAL WORK

in

THE FACULTY OF GRADUATE STUDIES

School of Social Work

THE UNIVERSITY OF BRITISH COLUMBIA

June 2009

Accepted as conforming to the
standard required for the
degree of Master of Social Work

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Abstract

Social work practice in the child welfare field has been punitive towards substance using mothers. This is due to the dominant discourse on this population in Vancouver, which has constructed substance using mothers as serious threats to their children in spite of little research that supports this view. A review of the research on this topic states that the lack of collaboration by social workers, the attitudes of social workers towards substance using mothers, and their lack of education about the process of addiction all contribute to poor outcomes for this population. Moreover, the system itself is flawed, as it uses invalid assessment methods when working with this population, as it ignores structural issues that the family may be facing and ignores the need for prevention. The implications for this are that women's concerns about the system need to be heard and in turn, social workers need to be better trained to meet their client's needs. Child welfare workers also need more support in doing their job and further research needs to be done to better service this population in the child welfare field.

Historically, social work practice with substance using mothers has been punitive (Greaves, Varcoe, Poole, Morrow, Johnson, Pederson, & Irwin 2002; Robert, 1991). Children have been removed at birth without a thorough assessment and these removals have been justified solely on positive drug screens on the newborn or the mother (Greaves et al. 2002, and Robert, 1991). Positive drug screens for many child welfare workers automatically denote that the mother is unfit to care for her own child and, in fact, a thorough investigation only begins after the child has been removed (Greaves et al. 2002, and Robert, 1991). Today, this practice has changed little and has been especially punitive towards Aboriginal women from lower economic backgrounds, largely due to the Gove inquiry in 1992. This inquiry into British Columbia's child protection system after the death of the child, Matthew Vaudreuil, resulted in the child protection system moving towards a child centered model, instead of a family support model that took into account a family's strengths (Bennett & Sadrehashemi, 2008).

As a result, child welfare workers have been using the "child's best interest" as a standard to assess a mother's ability to parent her children and therefore, the number of children in foster care increased from 6000 in 1994 to 10,000 in 1996 (Bennett & Sadrehashemi, 2008, p. 17; Greaves et al. 2002). What these perspectives ignore is the strategies mothers use to protect their children from their substance use (Richter & Bammer, 2000). Some of these strategies include maintaining a smaller dose of the substance to prevent withdrawal, preventing their child's exposure to activities associated with the drug trade such as not injecting in front of children, concealing drug paraphernalia, and preventing contact with drug dealers (Richter & Bammer, 2000). Moreover, children should not be deemed at risk merely because the parent was or is a

drug user, as many children with substance use in their families grow up healthy with no issues of concern (Garmezy, 1985, cited in Richter and Bammer, 2001).

Children who have been brought into foster care because of parental substance use are more likely to remain in government care for a longer period of time, are more likely to have been in multiple foster homes, and are less likely to be reunified with their families (Gregoire & Schultz, 2001). The implications for this are as follows. Children in care, especially Aboriginal children, have poor outcomes. For example, female teenagers who are in permanent government care in British Columbia are four times more likely to become pregnant than other teenagers (Bennett & Sadrehashemi, 2008).

Children are deprived of the right to grow up with their own families and this results in attachment issues for children in care, which can manifest itself into unfortunate situations in later life, including substance use (Hasenbeck, 2005). As for parents, the lack of reunification of one child can result in parents not being able to keep subsequent children. Hasenbeck (2005) argues that women who are denied the right to parent are denied the right to be “full participants in society” (Hasenbeck, 2005, p. 6). As a result, putting resources into reunifying families outweighs the cost to society, including high crime rates and subsequent generations of drug users (Hasenbeck, 2005). Therefore, the following graduating essay seeks to document how MCFD’s construction of substance using mothers has led child welfare practice into a punitive, risk based system. . The essay will begin with a discussion of reflexivity and then there will be an outline of the theoretical framework that will be used to analyze the literature on this topic. This will be followed by a review of the current research on this topic, which will begin by describing how MCFD’s child welfare practice has evolved into a risk based system.

This will be followed by a review of the current literature on child welfare practice and policy issues towards substance using moms. Finally this essay will conclude by providing a discussion on implications for social work practice for child welfare practice towards substance using mothers.

Reflexivity

My interest in this topic was developed out of my own experience both during my work as a child protection social worker and through doing a practicum for my Master of Social Work degree at Fir Square at BC Women's Hospital. I worked as a child protection worker for the Ministry of Children and Family Development (MCFD), Aboriginal Unit, in Vancouver, British Columbia for over four years. During these years, I worked on a specialized team where our clientele consisted of new mothers who had current or recent struggles with substance use. We worked from a strength-based model and met the clients where they were at and therefore, the majority of women went home with their babies and successfully parented their babies two and three years later. Consequently, a number of women in the community who were non-Aboriginal would pretend to be Aboriginal so that they could get serviced by our team. This was so because other teams were not as supportive, would remove babies at birth, and would not give women a chance to parent their children. However, after a change in staff on my team, things became more conservative and it was an everyday struggle to keep families together. This resulted in the end of my time as a child protection worker for the region because of the inconsistencies and lack of support when dealing with this population.

This frustration was amplified during my practicum at Fir Square, which is a specialized maternity unit where the majority of women have current substance use

issues. Here, I was shocked by the inconsistent response by MCFD towards this population. Some social workers were very supportive of this population parenting their children, while others were very punitive and acted quite inappropriately towards these mothers. This response did not come from just front line child protection workers, but also high-ranking Ministry staff as well. Children were being removed from their parents arbitrarily and without just cause, which was very shocking for me as I had been a child protection worker for several years. As a result, my interest in this topic was born out of my frustration with the child protection system in Vancouver and I wanted to give voice to the many women who are struggling to reunify with their children, articulate where there are gaps in services for these women, and expose contradictions in practice by child protection staff.

Accordingly, my epistemology lies within the social constructivist paradigm. I believe that maternal substance use has been socially constructed as causing child abuse or neglect. In Vancouver, this response has been largely punitive because child welfare officials have constructed maternal substance users as serious threats to their children. Therefore, this graduating essay seeks to bring together contemporary research pertaining to this population, as it contradicts the rationale behind current child welfare practice towards substance using mothers. Although not peer reviewed, the following essay will also contain the findings of a small qualitative study that sought to research the question, “What barriers do substance using women of colour face when they are trying to reunite with their children, who are in the care of MCFD in Vancouver?” This research study which was conducted as part of the requirements for a graduate level qualitative research methods class, sought to give voice to these women, as a lot has been written about them

and policy has been developed about best practices in working with them, without asking them to reflect on their own realities. Three women were interviewed for my study and their insights into current child welfare practice will be contained throughout this essay.

Theoretical Framework: Social Constructivist Feminism¹

Glenn, Chang, and Forcey (1994) define mothering as, “a socially constructed set of activities and relationships involved in nurturing and caring for people” (in Litzke, 2004, p. 49). What constitutes mothering also varies across time and place, from culture to culture (Boyd, 1999). Therefore, mothering is a social construct rather than what most have thought of as biological and instinctual (Boyd, 1999). Still, mothering is primarily associated with women and is a socially constructed term that has been used to “either demonize or idealize woman” (Litzke, 2004). Women of colour and poor women are demonized as mothers and are seen as unable or unwilling to raise children, overly promiscuous, and having too many children according to white middle class standards (Boyd, 1999). Substance using mothers have been demonized, as a negative discourse permeates this population because they do not meet the idealized view of what a mother is (Reid, Greaves, and Poole, 2008). Moreover, they are seen as not able to protect their children from harm and their households are stereotyped to be “disruptive, chaotic, and abusive” (Boyd, 1999, p. 10). .

This moral panic towards substance using moms is largely constructed by the media, who widely promoted the idea of the crack mom throughout the 1980’s and 1990’s even though women are less likely to use crack than men and crack use itself has been declining since the 1970’s (Boyd, 2004). Currently, “drug scares” perpetuated by the media are still evident where dominant discourses link drug use to racial minorities,

¹ Parts of this analysis was used in a final essay for SOWK 514A

especially women who are blamed for the breakdown of the family (Boyd, 2004, p. 20). This has led Greaves et al. (2002) to argue that the public's construction of substance using mothers is "fundamentally judgmental, blaming, and unsympathetic" (p. 6). In their analysis of media portrayals of substance using mothers, mothers were seen as threats to their children eighty-seven percent of the time (Greaves et al., 2002). This negative discourse towards these mothers was replicated in letters to the editor sections where hostility towards these mothers was expressed (Greaves et al., 2002). What was left out were father's roles, the woman's own socioeconomic status, or concern for the woman's health (Greaves et al., 2002). These social constructions in turn affect policy and the way women are treated in today's child welfare system in Vancouver. Feminist social constructivist theory will now be used to analyze the construction of substance using mothers in Vancouver's child welfare practice.

Literature Review

The following literature review will be separated into several themes that have been extracted from the literature. These include an overview of the drawbacks with the risk assessment model, the lack of involvement of fathers in child welfare, and concerns expressed about drug testing and inadequate services for this population. Moreover, a discussion about mothers' experiences with child welfare workers and foster carers as well as a discussion of the structural issues that affect this population will be presented. However first, there will be a discussion on the evolution of Vancouver's child protection practice.

A Preoccupation with Risk: How MCFD's Current Child Protection Practice has Evolved into a Risk-Based System

Child protection policy polarizes mother's rights against the rights of their children (Greaves et al, 2002). Mothers with a history of substance use are blamed and are automatically assumed to be abusing their children, which results in a punitive response towards this population. This punitive response is the result of media discourse on this population, which is usually fueled by stories of how mothers failed in their duty to protect their children. This in turn, steers policy. An extreme example of how the media representation of a case resulted in a change in policy and practice in child welfare was the death of Matthew Vaudreuil, where his mother, Verna, was convicted of manslaughter because of his death. This resulted in the Gove inquiry in 1996, where Judge Gove was commissioned to review child protection practice that led to Matthew's death. The Gove inquiry blamed social workers for putting the mother's interests ahead

of the child's and thus called for more child centered policy because he believed that children were social workers real clients, not mothers (Cradock, 2007).

What Judge Gove ignored was the mother's social circumstances and how their needs, in fact, were not met (Cradock, 2007). The mother had a brain injury and was sexually abused by both her biological father and her foster parents (Cradock, 2007). She also had over seventeen moves and eleven different foster placements by the time she reached the age of seventeen. Verna had asked MCFD for specific services numerous times before the child's death, but her requests were ignored (Greaves et al., 2002). This example clearly demonstrates how dominant discourses influence the lives of poor women, who make up child protection caseloads by influencing policy on how dominant groups construct what exactly constitutes child protection and how this is going to be dealt with. Judge Gove also stated in his recommendations that social workers, namely women, cannot be trusted to investigate their own mistakes and thus must have an independent officer to investigate all deaths and critical injuries (Cradock, 2007). The government had commissioned a panel to review child welfare practice, which included activists and the Aboriginal community, and found that the child welfare system was too punitive and needed to work with families holistically instead of just focusing on the child. However, the dominant discourse by the media was that the Gove inquiry was constructed as the "true" representation of the child protection system and thus, Gove's recommendations were put in place and the review panel's recommendations were ignored (Cradock, 2007). Thus came the era of child focused practice that ignored the needs and rights of mothers, as MCFD succumbed to the pressure by the dominant

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discourse to invoke punitive child welfare practice that focused on risk (Cradock, 2007). This ideology still steers child protection practice today.

Another more recent example was the Sherry Charlie inquiry that was created as the result of Sherry's death that was caused by the boyfriend of Sherry's aunt, who was caring for Sherry under MCFD's Kith and Kin Agreement. This case was handled by an Aboriginal child welfare agency, Usma. However, after this tragic incident occurred, the agency and the Aboriginal community itself was barred from being involved in both the investigation into child welfare response to this case, as well as coming up with recommendations to prevent this from happening again (Cradock, 2007). Cradock (2007) investigated the response to this death and uncovered how, although Usma was an independent agency responsible for child welfare and was in equal standing with MCFD, Usma was not consulted about the terms in the review and was "effectively sidelined" from the review (Cradock, 2007, p. 21).

To make matters worse, the government commissioned, yet again, a judge to review the child welfare response in the province. Even though Judge Hughes did write in his review that Aboriginal families should be serviced by Aboriginal child welfare authorities, he never once questioned why he, a Caucasian man, was chosen to do the review of child protection practice involving an Aboriginal child. This contradiction demonstrates how dominant discourse still creates child welfare policy and ignores the views of women and especially Aboriginal women, even though they make up the majority of child welfare cases.

This example further demonstrates how the province, although on the face of it, welcomes Aboriginal peoples to take over their own child welfare authorities and yet,

MCFD still exerts a lot of control over how these agencies should be run. These agencies are forced to replicate MCFD policies and administrative practices in order to be granted the “privilege” of taking over (Cradock, 2007). Cradock (2007) writes about how any attempts that Aboriginal people make to create an authentic version of child welfare that adequately meets their communities needs is undermined by MCFD policy that they have little influence over. Therefore, while being fully delegated, they must still work in the confines of patriarchal legislation and policies like the risk assessment, which were created without the population it sought to service at the table (Cradock, 2007).

Child protection legislation itself also contributes to the degradation of mothers. Cases of maternal substance use are categorized under “neglect” under the *CFCSA* when they are being investigated by child protection social workers. Although BC’s child protection legislation defines emotional abuse and sexual exploitation, it does not provide any definition or guidelines as to what constitutes neglect. As a result, there is a lot of guesswork by workers as to the scope and severity of neglect in individual cases and this is influenced by the individual social worker’s personal biases, as neglect is a social construction whose definition varies across time and place (Turney, 2000). MCFD does provide the BC Handbook on Child Abuse and Neglect for professionals working with children (Ministry of Children and Family Development, 2007). In it, the guideline provides examples of what constitutes neglect like poor nutrition, stealing food, and inadequate shelter, however, it makes no mention of the fact that these indicators may not be the result of parental blame but poverty (Ministry of Children and Family Development, 2007).

Moreover, none of the guidelines make any mention of substance use by the

parent as causing neglect and yet in Vancouver, this response has been largely punitive because child welfare officials have constructed maternal substance users as serious threats to their children. As a result, MCFD fails to provide an adequate definition of what constitutes neglect and therefore, individual social workers are left to define neglect themselves, and unfortunately, for many social workers, they have constructed maternal substance use as causing neglect without adequate evidence. These women are seen as incapable of raising children because they are seen as putting their “compulsion” to use drugs over their mothering role (Boyd, 2004, p. 128). On the contrary, numerous noteworthy studies show that substance using women can parent successfully (Boyd, 1999; Colten, 1980; Hepburn, 1993; Leeders, 1992; Lewis, Klee and Jackson, 1995; Lief, 1976; Murphey and Rosebaum, 1999; Siney, 1999; Sowder and Burt, 1980; Sterk-Ekufsibm 1996; Taylor, 1993; and Zarin-Ackerman, 1976, as cited in Boyd, 2004). Moreover, the research supporting intrusive action towards this population is faulty. For example, Diana Hogan’s 1998 review of research that supports the notion that the children of mothers of drug users have poor outcomes are done on alcohol users and not drug users and only focus on children in foster children who are already damaged (Boyd, 2004). This does not separate the diversity of drug users, including not separating by drug of choice and duration of use (Boyd, 2004).

Deconstructing MCFD’s Comprehensive Risk Assessment²

Child protection agencies have been undergoing turmoil since the early 1970s and referrals have gone up as high as 180%, there are higher caseloads with inadequate supervision, and there are cuts in resources and supports for clients (Krane & Davies, 2000). As a result, child welfare agencies in North America and the United Kingdom

² Parts of this analysis on the risk assessment were used for a research proposal for SOWK 554C

have sought a more efficient and standardized tool to assess risk (Krane and Davies, 2000). The risk assessment has been introduced as a way to effectively determine if the child is at risk for future abuse (Krane and Davies, 2000). Those in support of such tools have argued that risk assessments reduce any biases that the social worker may have and are an objective tool for assessment (Krane and Davies, 2000). However, others have argued that risk assessments have little empirical validity, as their level of predictability for future harm is questionable (Corby, 1997, cited in Krane & Davies, 2000). In fact, the likelihood of getting a false positive on a risk assessment is very high, around fifty percent (Pecora, 1991, cited in Krane & Davies, 2000). This is so because child abuse is not “identifiable or predictable” (Krane & Davies, 2000, p. 37). Despite this, risk assessments are increasingly being used even though there is little corroboration that the tool works to better discover and avert abuse or neglect (Krane and Davies, 2000). This is problematic because the completion of a risk assessment is a prerequisite before reunification in British Columbia, as the level of risk must be reduced from the original assessment in order for children to come home. Thus, dominant discourses have constructed what exactly defines risk, and what is to be done to reduce risk without any adequate evidence supporting these findings of risk in the first place (Scourfield and Welsh, 2003). Risks are social constructions that further promote the agenda of mother blame among substance using mothers. This has led Taylor-Gooby (2001) to conclude that child welfare practice based on risk is, “Class ideology masquerading as social theory: it serves the interests of those already privileged in a more flexible society by obscuring the needs and aspirations of the more vulnerable, who already bear most of the burdens of social change” (in Scourfield & Welsh, 2003, p. 407).

As the risk assessment has been found unreliable to predict future risk, it is preventing many families from reunification (Greaves et al., 2001). This is due in large part because abuse is a social construction and cannot be operationalized due to the fact that what constitutes abuse varies across time and place (Krane and Davies, 2000). Brissette-Chapman (1997) argues that abuse is “culturally constructed” and this is why in the United States, a disproportionate number of African American children are brought to care (cited in Krane & Davies, 2000, p. 38). This is congruent with the over-representation of Aboriginal children in care in Canada. Therefore, the likelihood that the risk assessment tool is standardized is unlikely, as it rests largely on the worker who is completing it and his or her values and biases that usually put the brunt of scrutiny on the mother (Krane and Davies, 2000). Moreover, as described above, social workers have been found to discriminate against substance using mothers and therefore, risk assessments would reflect this bias.

Risk assessments also further disconnect workers from the realities of their clients because it leads to identifying risk without further investigation (Krane and Davies, 2000). For example, “living conditions” is a risk factor included in British Columbia’s risk assessment model (Child Protection Consultation Service, 1996). In it, a family’s home is considered “extremely unsafe” if there are “repeated episodes of eviction and/or homelessness” (Child Protection Consultation Service, 1996, p.58). The problem with this is that it assumes risk without looking into the context of why a mother would be unable to secure consistent housing (Kane and Davies 2000). In Vancouver, chronic homelessness is a reality for many families because of the lack of safe, affordable housing. Where there is affordable housing, it is usually around areas with open

substance use, which is counter-productive to some mothers in early recovery. Likewise, the risk assessment model prevents reunification because its chief focus is on the mother's pathology without looking at the social context of their lives (Krane and Davies, 2000). As a result, Krane & Davies (2000) argue that the risk assessment model "reproduce(s) oppressive gender relations and mother blame" (42).

The BC version of the risk assessment also highlights four risk factors that are believed to be "highly correlated" with future harm to the child (Child Protection Consultation Service, 1996). These factors include Parental Abuse as a Child, Parent's Substance Use, Family Violence, and History of Abuse to the Child (Child Protection Consultation Service, 1996). These four risk factors blame mothers for the abuse that they have suffered and the consequences of this abuse, which is sometimes substance misuse. Most substance using mothers have been the victims of abuse as children and as adults (Boyd, 2004). This combined with the fact that MCFD automatically assumes that a mother who uses substances is abusing her child would mean that substance using mothers more likely than others would have all four risk factors "highly correlated" with risk of future abuse of her children. This is contradictory because most of these women were in MCFD care as children and instead of servicing these women as children and helping them overcome their abuse as children, they are further stigmatized when they become parents. One woman who participated in my study was particularly upset about this risk factor and stated, "It seemed they judged your past and they should have no right to but they do. I just found that it was a battle and I feel bad that them doing that. It's not right." As a result, MCFD not only fails these women as children, but also as adults and the cycle of surveillance by MCFD is likely repeated for generations at a time.

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For families where substance use is a key issue, MCFD provides a companion to the risk assessment titled, *Practice Guidelines for Assessing Parental Substance Use as a Risk Factor in Child Protection Cases* (Weaver, 2007). This document states that its purpose is to “provide information and direction for child protection workers to assess the risk of future child abuse or neglect related to parental substance use” (Province of British Columbia, 2001, p. 2 in Weaver, 2007). However, this “companion” is full of contradictions and inconsistencies. These guidelines state that the needs of the parents are always inferior to the needs of the child (Weaver, 2007). This goes along with patriarchal assumptions where the focus is on the child without looking at the family holistically.

The guidelines also speak to the fact that addiction is a reality for many families in child protection work, however, the guidelines fail to acknowledge structural issues on why families come to the attention of child welfare authorities and how to best meet the needs of this population (Weaver, 2007). The guidelines go on to say that social workers cannot automatically assume that substance abuse in itself leads to abuse or neglect (Weaver, 2007). However, the fact that MCFD had to create this document contradicts this statement (Weaver, 2007). This document does not promote working with substance using parents in a collaborative way or providing information about addiction to workers. Instead, it continues to promote a punitive discourse by declaring that workers must not give parents too much attention and that the focus should be on the child. As a result, this document hardly promotes collaboration or strengths based practice.

As a result, the risk assessment model’s chief focus is on the mother’s pathology without looking at the social context of their lives (Krane and Davies, 2000). Therefore,

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Krane & Davies (2000) argue that the risk assessment model “reproduce(s) oppressive gender relations and mother blame” (p. 42). Moreover, even though social workers are aware of women’s oppression and linking the personal to the political, mothers’ actions are still constructed as individual choices without looking at how poverty, racism, and sexism has affected their families’ lives (Krane and Davies, 2000). As a result, the burden for mothering still is on the shoulders of women while men escape any kind of scrutiny even if he is the perpetrator (Krane and Davies, 2000).

Blaming Mothers, Ignoring Fathers

Although inquiries into child deaths repeatedly show that children are most likely to die at the hands of male caregivers, child protection workers still put the brunt of scrutiny on mothers and fail to acknowledge that men are more likely to abuse than women (Milner, 1993). Moreover, when there are sexual or physical abuse findings against a father, the mother is also found to be neglectful for allowing this to happen even though she may have been a victim of abuse by the man as well (Milner, 1993). This not only serves to let men off the hook or make their abuse less serious, but also increases mother blame (Milner, 1993). In fact, the child protection file is put under the mother’s name and she is the one that bears the brunt of following through with whatever intervention the child protection worker mandates the family to complete. If a woman has a substance use history, they are held even more culpable for the abuse that the male perpetrated against the children. This reflects dominant discourse as to how women and men’s roles are constructed. Mothers have different expectations than fathers and when mothers are found to be abusing children, men are never implicated for not protecting their children from mothers. Milner (1993) argues that this occurs because society has

clearly defined what a mother's role is, that of nurturer for the child, however, the construction of the role of the father is obscure and so it is harder to scrutinize.

This process of scrutinization for substance using mothers begins at pregnancy and then throughout the infant's life where the health nurse drops in while men escape any kind of scrutiny during this stage (Milner, 1993). Moreover, these same reviews into child deaths have shown that grandmothers and foster mothers have warned child protection authorities about increased risk in the home and their fear of the children being seriously hurt, yet their voices are ignored while the assessments of men, particularly doctors and police officers, are taken seriously (Milner, 1993). This is so even though grandmothers and foster mothers know parents in a more intimate way whereas doctors and police officers have shorter and less deep contact with clients (Milner, 1993). Yet, their voices continue to be ignored by child welfare workers.

Drug Treatment and Support Services

Once there has been a finding of risk in the home, mothers can feel a sense of disempowerment, including feeling as though their identity has been damaged (Croghan and Miell, 1998). This leads to their viewpoints being overlooked and therefore, social workers project on to them what they need to reduce the risk in the home (Croghan and Miell, 1998). If women disagree with this assessment, they can be constructed as resistant and therefore, would not get their children returned to them. However, if she did accept them, these mandated services might not be meeting her needs (Croghan and Miell, 1998). This is so because dominant discourse on what is "wrong" with these mothers prevails and mother's perspectives of what they need are ignored. Moreover, these support services usually look at parental pathology instead of looking at structural

reasons as to why there would be “risk” in the home. Therefore, mothers must accept professional discourses on her own situation and this results in mother blame. It ignores the fact that “bad mothers” have insight into their own situation and are the experts in their own lives (Croghan and Miell, 1998). This is concerning because the majority of child welfare clients are disadvantaged socially and at least half are in relationships with violent men (Croghan and Miell, 1998).

Although mothers who are struggling with substance use make up about eighty percent of the cases on child welfare caseloads, due to the chronic disposition of addiction and the lack of appropriate services, the needs of mothers with addiction to substances are not being met (Smith, 2006, Hasenbeck, 2005). This is counter-productive as the level of social supports that a mother has is directly correlated to reunification and less child welfare involvement after reunification (Gregoire & Schultz, 2001). Smith (2006) found there was also an absence of a family focus at treatment centers and a lack of women centered and culturally appropriate addiction services. There is also a lack of coordination between addiction and child welfare services (Smith, 2006). Therefore, mothers reported feeling as though they were being pulled in two different directions where addictions services would be telling them to do one thing and child welfare officials would be advising them to do something else (Hasenbeck, 2005; Krane & Davies, 2000; Smith, 2006). Drug treatment staff felt that child welfare officials were not consistent with their clients, were “undermining of maternal efforts,” and were very arbitrary in their decision-making (Linares, 1998, p. 254). Alternatively, child welfare officials found drug treatment staff to be not collaborative and judgmental (Linares, 1998). This lack of clarity between staff poses a barrier for women because they are the

ones who get caught in the middle and the reunification process is hindered (Linares, 1998).

After care support was also found to be of an issue (Azzi-Lessing & Olsen, 1996; Hasenbeck, 2005). There is a need for transitional housing post treatment and post reunification where families would live in housing with supports (Hasenbeck, 2005). Moreover, the need for ongoing therapy is also important. Therapy was found by Hasenbeck (2005) as the most critical feature that helped substance-using mothers reunify with their children, as it allowed them to confront the reasons why they started using substances in the first place. A history of childhood abuse is cited as a major cause of relapse and therefore, if resources are not put into addressing this, successful reunification is not a realistic goal (Karoll, 2002).

Mothers also report that child welfare officials do not provide mothers with information about why referrals to certain supports are made and the consequences of not complying with treatment plans (Azzi-Lessing & Olsen 1996). Mothers described the child protection system as being too slow because they had to wait months for mandated services to begin, which social workers expected them to complete before reunification (Hasenbeck, 2005; Smith, 1999). This is especially problematic because time pressures that child welfare authorities impose are incongruent with the process of recovery (Carlson, Matto, Smith, & Eversman, 2006). In the United States, if a child is in care fifteen out of the last twenty-four months, the social worker must apply for a permanent custody order (Carlson, Matto, Smith, & Eversman, 2006). In British Columbia, the legislation states that the Director must apply for a Continuing Custody Order for a child under five if that child has been in temporary care of the Director for one year (Greaves

et al., 2001). This time-period is too short for mothers in recovery, especially given that services take months to put into place.

The Vancouver region of MCFD employs family preservation workers to work with families in reducing risk. This is a mandated service where families must engage with family preservation workers or risk having their children removed from their care or not have their children returned to them. Although family preservation workers, like their name suggests, were supposed to help keep families together, as family preservation services have increased, so have the number of children who are removed from their parent's care (Harris, Russell, and Gockel, 2007). This increase has especially been detrimental for Aboriginal parents, as the number of children in care has jumped from less than 1% in 1951 to as high as 80% currently (Harris, Russell, and Gockel, 2007). One of the factors that contribute to this is that family preservation workers are contracted by MCFD to further its agenda by exerting social control over substance using mothers. They are not supports to the family as constructed by MCFD, as the goals that they must work on are MCFD goals, not the mother's goals. Family preservation workers also must report all their findings to MCFD and MCFD has access to all records. This prevents mothers from being candid and trusting their family preservation worker and thus, prevents a useful helping relationship from forming. Moreover, in a study by Harris et al. (2007) on Aboriginal mothers involved with family preservation services, they established that women found that after the cutbacks to the MCFD when the Liberal government took over, these services also became less collaborative and more outcome based (Harris, Russell, and Gockel, 2007). Consequently, MCFD establishes risk and forces mothers to accept support services that are not meeting their needs.

Drug Testing: The Social Control of Mothers

In the past, once a woman gave birth and had a history of substance use, doctors never used to call child protection services, however, current societal attitudes towards this population have resulted in calls to child protection without any assessment of her supports (Boyd, 2004). This shift in attitudes reflects the social regulation of women (Boyd, 2004). A way that this has been done is through drug testing of mothers or babies without the mother's consent and little attention is paid to the ethics of this. My work experience at MCFD's Provincial After Hours program illustrated how this is still happening, as doctors all across the province would call to make a report about a mother who gave birth to a child and meconium testing showed that there were illicit drugs in the child's system. This testing was done without receiving consent for this testing of her child.

After children are removed, women further undergo extensive and lengthy drug testing before children can go home. This practice continues even though urine and hair testing has been found to be quite unreliable and does not provide insight into a woman's history of substance use (Boyd, 2004). For example, drug testing cannot distinguish between the first time user, the occasional user, or the hard user (Boyd, 2004). Still, child protection workers in Vancouver choose to decide a mother's fate by relying on drug testing even though this gives no information on a mother's parenting ability (Boyd, 2004). Drug testing is also disproportionately done on poor women of colour. For example, in a Florida study on drug testing, it was found that African American women were ten times more likely to be tested than white women (Boyd, 2004).

Drug testing has been defended by those in positions of power stating that drug use needs to be identified so that babies can be screened and treated for Neonatal Abstinence Syndrome (NAS). Boyd (2004) argues that NAS is a social construction insofar that those in positions of power have automatically assumed that any woman that uses illicit drugs damages her fetus. “Moral reformers” whether it is doctors, lawmakers, or social workers, have created the moral panic of crack baby in the midst of any significant medical evidence that states illicit drug use causes permanent disability in children (Boyd, 2004, p. 94). In 1998, a report by the BC Provincial Health Officer stated that these children face “a lifetime of social, physical and psychological” problems, like flawed communication skills and aggression (Boyd, 2004). However, there is no evidence to support this and this also ignores the fact that poverty, not substance use has the most negative impact on a baby’s health (Boyd, 2004).

Boyd (2004) has further found that the research used to support the notion that crack use results in negative effects on fetus’ have been done on poor women whereby the affects of poverty have been mistaken for crack use (Boyd, 2004). This negative notion was supported even though the fact is that the majority of babies exposed to crack have normal birth weights especially when women have adequate nutrition and prenatal care (Boyd, 2004). In fact, Frank et al. (2001) reviewed studies on prenatal crack exposure from 1984 to 2000 and found that infants exposed to crack are “indistinguishable” from those who are not exposed (in Boyd, 2004, p. 96). Moreover, there is no such thing as withdrawal from crack (Boyd, 2004). Still, when social workers call into the hospital, they ask if the child is withdrawing and if the social worker or nurse says that the child is not, they think that the hospital worker is lying or keeping

information from the child protection worker. As a result, withdrawal and the negative effects on children of illicit drug users is a social construction that has been created in North America as 60 to 95 percent of babies exposed to drugs will be categorized as experiencing withdrawal whereas only seven percent of these babies are categorized as experiencing withdrawal in Glasgow (Boyd, 2004). This illustrates how negative effects of illicit drugs on children is largely a social construction.

The Role of Foster Carers in Devaluing the Mothering Role

Mothers are further stigmatized by the foster care system (Greaves et al., 2001). Greaves et al. (2001) argue that the “structure and language” of the foster care system further symbolizes that biological mothers are bad mothers (p. 68). When children are brought into care, the caregivers are referred to as foster “mothers” and foster “fathers” by the children and this results in birth mothers being stripped of their mothering role (Greaves et al., 2001). Instead, the authors suggest that foster carers should be referred to as aunts or uncles because this still allows children to acknowledge them in a close way, but more importantly, allows the mother to keep her title (Greaves et al., 2001). In the United Kingdom, the term foster parent is foreign, and the terms foster carer or caregiver are used to maintain connection to biological parents. Moreover, Reid et al. (2008) criticize the fact that foster carers are given significant resources to raise children while the needs of birth mothers are ignored. This again reiterates dominant discourse over who in fact has the right to parent. As the majority of children in care are Aboriginal or are immigrants and the majority of foster parents are Caucasian, this sends a clear message of who society believes is deserving of parenting. These children are raised in a system that strips them of their cultural identity and thus, perpetuates neo-colonialism.

This also symbolizes the devaluation of mothering by women of colour (Reid et al., 2008).

An example of foster carers over stepping their role and MCFD not intervening came out in my research. One woman had three children with foster carers and found that they took control over every aspect of the children's lives, including which church they went to. They would also sit down with the children after a visit with their mother and bring out a bible, stating that the children had to tell them everything that happened during the visit. In another instance, the family was accepted into a family treatment centre, which had an extensive waiting list, and the family did not end up going because the foster carer advised the social worker that he did not think it was a good idea because the children would miss too much school. Moreover, she described how the foster carers would tell her children that she was using when she was not,

When I went to Alberta in January last year, I had to go because my mom was really sick. They (foster carers) told my kids, "Oh she's just lying, she's not there, she's just drinking with her friends." You know they would say things like that to my kids and my kids would be worried about me.

She described how this has affected her children now,

I think they should have listened to my kids a lot more...it's really upsetting, the stuff my kids had to go through. The three young ones all have separation anxiety right now. They have severe anxiety right now. She wasn't even functioning in school. She calls me everyday just to, just to make sure that I come. We have to use a cell phone. She's got post-traumatic stress disorder, you know. We've been complaining right from the beginning. My kids have been complaining.

In contrast, another woman's son in my study had an extremely supportive foster carer, with whom she continues to have contact. In the interview, she stated that, "The beauty was that their family loved him so much, it changed my life, it made a big difference." She was allowed eight hour visits everyday in the foster carers' home and she felt as though this foster carer really loved her children and was not in it for the money. This helped her in her recovery, knowing that her child was well taken care of and the frequent contact reiterated this. She also stated that having a supportive foster carer resulted in her getting her child back sooner.

Mother's Perspectives on Child Welfare Social Workers

The most frequent objection that mothers had with social workers was their insensitive views about addiction, recovery, and relapse (Carison, Smith, Matto, & Eversman, 2008; Greaves et al., 2001; Hasenbeck, 2005; Smith, 1999). Social workers' attitudes were found to be negative towards parents with substance use issues and this led the worker to shun or even punish mothers (Hasenbeck, 2005; Smith, 1999). When women are identified as having a past or present substance use issue, social workers automatically assume that they are abusing their children without any concrete evidence. Therefore, social workers feel as though they have a right to control every aspect of their lives. For example in my study, one woman's social worker would tell her exactly who she could and could not hang out with. She stated that social workers controlled, "When you go out, who's talking to you, who you can talk to. Who I talk to shouldn't matter as long as the kid is getting fed and cared for". As a result, social workers felt that they had to control every aspect of women's lives because their construction of what constitutes a

bad mother is someone who had a history with substance use. Consequently, this woman felt as though she was on probation.

Women also feel increased stigma when they relapsed, as workers would automatically assume that the mother was back into her addiction and did not understand that relapse is a normal part of recovery (Hasenbeck, 2005; Karroll, 2002; Smith, 1999). Therefore, mothers have felt that social workers over emphasized their drug addiction when assessing risk and ignored strengths that were present in the family dynamic, which included the mother-child bond, family supports, parenting skills, and the availability of respite support (Azzi-Lessing & Olsen, 1996). Similarly, mothers found that their social workers felt that they did not have the capacity to change because they had a substance use issue (Bennett & Sadrehashemi, 2008). Mothers also felt as though reunification was too dependent on clean drug screens without looking at strengths and signs of safety within the home (Azzi-Lessing & Olsen, 1996). Moreover, workers were insensitive to the fact that substance use may increase right after a mother's child is removed because of the trauma that apprehensions cause (Azzi-Lessing & Olsen, 1996). Instead, social workers viewed this as more evidence for their case against the mother and further justification that the removal was in the best interests of the child (Azzi-Lessing & Olsen, 1996). Women also felt as though they were not heard. This was especially troubling for one woman who participated in my study, who spoke out about the lack of involvement of Aboriginal women by child welfare workers,

With the social workers that I had, they worked with me. Sometimes they heard, sometimes they did not, but most of the time we're not (heard). If you want me to

succeed like you say, then help me and not sit there and judge me. Talking with me, not going in one ear and out the other.

She stated that the social worker did not understand and judged her, which made it harder to get the child back because it contributed to relapse. For example, one day after she had relapsed, she went to see her social worker and told her about the incident. Instead of getting a supportive response, her social worker was waving her finger at her and made her feel as though she was the worst person for using and also made her feel as though she would not get her child returned to her. This made her go out and use again.

Mothers also felt as though their social workers were not clear about expectations and social workers were not available to answer their questions about how they came to their decisions or even how the child welfare system worked (Bennett & Sadrehashemi, 2008; Hasenbeck, 2005). Workers are also seen as being insensitive to lower income women who may not have access to telephones, bus fare to attend appointments, or adequate child care (Azzi-Lessing and Olsen, 1996). Mothers also expressed concerns about the high turnover at child welfare agencies where they would just get used to working with a particular social worker and then have to get used to a new social worker who knew little about their case (Bennett & Sadrehashemi, 2008; Greaves et al., 2001; Hasenbeck, 2005).

Accordingly, the essential values of the social work profession seemed to disappear when social workers were dealing with mothers with substance use issues (Bennett & Sadrehashemi, 2008). Compassion, being non-judgmental, and believing that everyone has the capacity to change disappear when dealing with this population. Moreover, empowerment and working to build trusting relationships also seem to vanish

when social workers work with this population. Unfortunately, this has led to women feeling powerless, especially when there are no clear effective methods to making complaints about workers (Hasenbeck, 2005).

Questionable Ethics

The case of *Winnipeg Child and Family Services v. G.* illustrates an example where child protection authorities over stepped their power and tried to forcibly enroll a pregnant woman into treatment (Roy, 2005). The child protection authority in Winnipeg argued that Ms. G should be forcibly made to go to treatment in order to “save” her fetus from the effects of her substance use (Roy, 2005). They tried to do this under the province’s *Mental Health Act* even though there were psychiatric assessments that contradicted the belief that she had a mental disorder and could not act in her own best interest (Roy, 2005). Eventually the Supreme Court of Canada reversed the original court’s decision that Ms. G would be forced to go to treatment, as a fetus has no rights under the law and thus, no action can occur on behalf of the fetus (Roy, 2005). Moreover, Justice McLachlin asserted that for a public body to take action to protect the fetus over the rights of the mother would radically impinge women’s self-determination and freedom (Roy, 2005).

During my three-month practicum experience at a hospital unit that works primarily with substance using new mothers, I witnessed how this Supreme Court decision was breached by local child welfare officials. There was a meeting held at the hospital unit with a consultant from MCFD at the request of hospital staff. This meeting was requested because a number of child protection social workers were sending requests for women’s charts, which contained their medical history even though they had not

given birth yet and there was no child. During investigations, social workers are allowed to access any records that fall within the jurisdiction of the *Freedom of Information Act* under section 96 of the *Child, Family, and Community Services Act*. However, if a woman has not given birth, they cannot access it as there is no child, as the Supreme Court decision in the Ms. G case illustrated. However, a child protection consultant for Vancouver contradicted this and insisted that any delegated child protection social worker that receives a report about a pregnant woman can investigate and therefore, has access to all of her personal medical records. She insisted that this was the law and that the hospital could not prevent this from happening. This practice by the Vancouver region of MCFD is a complete violation of women's rights, rights that were upheld in the Supreme Court decision of Ms. G's case. Moreover, the consultant also advised that child protection social workers have a right to interview the expectant mother on their own, without a support person present. This is also a violation of a woman's basic right, as mothers always have the option of having a support person present. This practicum experience uncovered just a few of the unethical practices that MCFD in Vancouver is practicing with this vulnerable population. What is surprising is that this is coming from a senior official in MCFD and not a new worker who may not know the legislation. When I have disclosed this information to my colleagues that work in child protection, they are shocked that anyone let alone a consultant would endorse such practices.

Structural Biases: From Racism to Poor Bashing

Reports of maltreatment against poor, single mothers are arguably due to poverty rather than parental pathology, however, these social factors are, for the most part, ignored by child welfare workers (Krane & Davies, 2000). Swift's (1995) review of

child welfare assessments found that workers made virtually no link between presenting problems in child welfare reports and the client's socio-economic status (in Krane & Davies, 2000). Instead, mothers were pathologized as women who cannot take care of their own children (Krane and Davies, 2000). To accept these risk factors without placing them into the context of women's lives is equivalent to "embrace(ing) them as appropriate markers of deviation from a mythical, eurocentric, middle class conception of proper mothering" (Krane & Davies, 2000:41). It also ignores mother's first hand knowledge of parenting through experience in spite of largely oppressive social conditions (Brown, 2006).

In Canada, impoverished Aboriginal mothers make up the majority of these cases where children end up in foster care (Bennett & Sadrehashemi, 2008). For example, in 2006, the number of children in care that are Aboriginal exceeded non-Aboriginal care for the first time (Bennett & Sadrehashemi, 2008). Aboriginal families are more likely to be reported to child welfare agencies by the public, especially health care agencies (Bennett & Sadrehashemi, 2008). Alternatively, middle class white women do not have to worry about these toxicologies because their social location is more equivalent to hospital and child welfare officials (Bennett & Sadrehashemi, 2008). Child welfare social workers in Canada are mostly white, middle class women whereas their clientele are disproportionately poor women of colour (Davies, Krane, Collings, & Wexler, 2007). Consequently, Roberts (1991) argues that this phenomenon is the result of the larger society deciding who is deserving and undeserving of motherhood, thus discouraging certain groups from procreating. This is illustrated by the fact that over eighty-five percent of Aboriginal children in care in British Columbia are placed in Caucasian homes

(Bennett & Sadrehashemi 2008). Moreover, MCFD divides its cases into “Aboriginal” and “Non Aboriginal” and Bennett & Sadrehashemi (2008) have found that a disproportionate number of “non Aboriginal” children that are removed from their parents care are children of recent immigrants. This symbolizes the devaluation of Aboriginal and non-European motherhood in Canada and ignoring the effects of colonization on this population. For example, mothers who do not conform to a Eurocentric standard of mothering, where the mother is the primary and only caregiver, are seen as deviant when in collectivist cultures, mothering is shared by other women kin and older siblings of the young child (Krane & Davies, 2000; Linaire 1999). Roberts (1991) equates this practice to “racial eugenics” and compares this to historical practices of sterilization of minority groups to prevent procreation (1472).

Boyd (2004) also found a report done in BC in 2003, which identified that the majority of removals occur under neglect, and not physical or sexual abuse. This has led child neglect researcher, Karen Swift, to argue that neglect is a category used by those in positions of power to oppress impoverished mothers, especially those who are racialized (in Boyd, 2004). Instead of looking at how societal conditions have caused single mothers to live in poverty, poor women are hypothesized as not wanting to improve their lives (Boyd, 2004). In 2001, Premier Gordon Campbell’s BC Liberals came into power and drastically slashed income assistance rates (Boyd, 2004). Single mothers saw their welfare rates reduce by forty-six percent, which only covered 45 to 65 percent of the actual cost of living (Boyd, 2004). During this time, homelessness in Vancouver also increased by 94 percent (Eby and Windsworth, 2008). This symbolized a shift in ideology from helping the poor to poor bashing (Boyd, 2004). This results in poor

bashing where these women are seen as “dependent and deviant,” which serves to let society off the hook for racism, colonialism, and sexism (Boyd, 2004, p. 126). This is especially troublesome for women whose children are removed from their care, as their income assistance cheques are ghastly reduced to below the poverty line and most end up becoming homeless as their shelter portion is reduced to a single person.

The preceding literature review and examples from my own experience and research illustrate a child welfare system in Vancouver that is inherently flawed and continues to fail substance-using mothers. In fact, the basic rights of mothers are not being honoured. Mothers are unaware of what they had to do to get their children back, as when they completed one program, the social worker would have a list of other things that they needed to complete. Therefore, instead of working from a holistic and woman-centred lens, child protection practice is individualistic and disempowering and ignores the diversity of its clients (Boyd, 2004). Accordingly, this has led Reid, Greaves, and Poole (2008) to ascertain that the “paternalism, control, and insensitivity” by MCFD results in a failing response to this population (p. 227). MCFD ignores the factors that led these women to use substances in the first place, which are intergenerational drug use, racism, abuse, and poverty (Reid et al., 2008). All three women who participated in the study were involved with MCFD as children and all began using substances as youth. Instead of acknowledging this, or supporting women in dealing with addiction and reuniting with their children, these women are punished. Not only are their voices are ignored but as one woman’s story from my study illustrated, their children’s voices are ignored as well. This is especially troubling for Aboriginal women who are vastly over-represented in child protection cases because of their unique histories of colonization and

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the intergenerational effects of this. As a result, their fate, as well as their children's fate, is decided by an unqualified public body through ongoing surveillance but little support (Reid et al., 2008). I will now shift focus on changes that I believe will make child welfare practice in Vancouver more welcoming for this population.

Implications for Social Work

The Need to Focus on Strengths

Feminist social construction theory is premised upon the fact that reality is socially constructed and is based on the way women define their realities (Krane & Davies (2007). In child welfare practice, the day-to-day realities of women are ignored and are not taken into account in assessments on children's safety (Krane and Davies, 2007). Child protection workers are seen as experts and their opinions are seen as more valuable than the woman's construction of her own reality and needs (Greaves et al., 2002). Therefore, MCFD assessments are invalid, incomplete, and prejudicial. Consequently, women are not receiving the services that they need and instead, the social work relationship with substance using mothers is built on mother blame and patriarchal notions of control and power over substance using mothers (Krane & Davies, 2007). Thus, a positive maternal identity is effectively destroyed by the dominant discourse that substance users are bad mothers.

In order to address this, child protection workers need to work more holistically and understand that what is in the best interest of the child is not separate from the interests of mothers. They need to be more aware of the realities that these women are living. In order to do this, social workers need to develop a mothering narrative in order to understand women's lived realities because women would be empowered to express both the challenges that they face as mothers and their own interpretations of what is going on in their family's lives (Davies and Krane, 2007). Allowing women to express the stress and physical as well as emotional challenges of mothering would enable more compassion and empathy from social workers that may not understand the social

conditions that women must overcome in order to parent (Davies and Krane, 2007). Focusing on a mothering narrative would also allow workers to come up with deeper, more accurate assessments because they would get a more in depth snapshot of the struggles that these women face (Davies and Krane, 2007). In turn, the social worker could learn from the mother about what would be helpful to her at this time (Davies and Krane, 2007). This way, Davies and Krane (2007) argue that, “the worker creates a space for sensitivity both to the woman’s personal account of mothering and to the broader socio-cultural constructions which shape her maternal subjectivity” (p. 29). This development of a mothering narrative also challenges the dominant discourse of what good mothering is (Krane and Davies, 2007).

Likewise, Greaves et al. (2002) argue that a positive risk assessment should be created in order to replace the current model. Instead of calculating the risk that a parent will fail in protecting their child, the positive risk assessment would calculate the potential for success (Greaves et al., 2002). This would include assessments on the mother child bond as a major strength and would result in MCFD actually investing in prevention and support. Consequently, feminist and strength-based approaches to child welfare practice need to be emphasized in child protection. Social work students are taught this in school but once they are employed in child welfare agencies, this does not translate into practice.

Increasing Training for Child Welfare Workers

Child protection workers need to receive training in addictions, including an overview of addiction theories and how to practice harm reduction in child welfare. Moreover, they need additional information on subcultures among drug users in order to

address anxiety and stereotypes that social workers project on to this population (Weaver, 2007). In Weaver's (2007) study on child protection social workers in 2002, even though sixty-nine percent of child protection worker's caseloads were comprised of substance using mothers, the workers rated their own knowledge of substance use theory and interventions as "relatively poor" (p. 77). For example, child protection workers rated themselves a 2 out of 5 on their own knowledge of the stages of change model and a 2.8 on their knowledge of harm reduction (Weaver, 2007). Moreover, seventy percent of workers rated their knowledge of empowerment based practice as a 3 or less (Weaver, 2007). This influences the helping relationship with clients, who get frustrated with the lack of education of social workers. As one woman who participated in my study stated, "It would be nice if the social workers had more understanding of addictions. Because they haven't been there, don't sit there and judge somebody when you've never been there." When this woman finally got a social worker that understood addictions and mental health, her identity as a mother changed. She stated that her social worker told her, "I'm really proud of you, you're really doing a really good job, just keep up the good work." This made her feel as though for the first time since she got involved with MCFD,

I'm finally getting the praise that I needed and feeling like yeah, I'm gonna be a mom again whereas before, through this whole, three and a half years with the other workers, I didn't feel like that.

Weaver's (2007) study also found that MCFD had provided little training on addictions. In fact, my own experience in over five years of working for MCFD found that there was no training on addiction except for one seminar in the community that did

provide training on the stages of change model, which most social workers had never seen before. After the training, most were quite delighted with the model and wanted more information on how to use it, however, nothing has been offered since. In fact, I had to take courses through Vancouver Community College's addictions counselor program in order to gain more knowledge in this area, as my training at the Bachelors of Social Work level did not ready me for working in this area. Consequently, Schools of Social Work need to integrate addictions training into their child welfare specializations. As these students are most likely seeking employment in child welfare agencies, they need to have addictions training because most child welfare caseloads include substance use as an issue and depending on which community one is practicing in, substance abuse as a factor could be as high as 100% of one's caseload.

Supporting Child Protection Social Workers

The high turnover rate in child protection extends the period of time that children remain in care, as the new worker may take weeks getting to know the file and meeting with the client in order to complete their own assessments on the family. Bennett, Sadrehashemi, Smith, Hehewerth, Siemena, and Makolewski (2009) completed a study on the reasons why child protection workers are leaving MCFD. They found that a third of respondents stated that the reason they left their jobs were due to high caseloads and workload issues (Bennett et al., 2009). Moreover, around seventy percent of respondents said that they would have "very likely" stayed with MCFD if their caseloads were reduced (Bennett et al., 2009, p. 8). Reduction of caseload was the highest rated factor, even more so than increased salaries (Bennett et al., 2009). Moreover, social workers expressed concerns over the fact that vacancies were not filled and there was no coverage

during vacations or sick leaves (Bennett et al., 2009). High turnover rates and paperwork requirements mean that social workers do not have time to spend with their families in order to build relationships and really get to know them. The staff turnover rate for MCFD is ten percent and MCFD has the highest sick days taken when compared to all public service employees (Bennett et al., 2009). This also prevents strength-based practice. Over sixty-five percent of the respondents advised that they were “rarely” or “never” able to give their families adequate attention and instead, were only able to respond to crisis (Bennett et al., 2009, p. 10). Moreover, workers did not feel that there were inadequate services to meet their client’s needs and that services were not culturally appropriate (Bennett et al., 2009).

MCFD also currently has a hiring freeze. Although the Liberal government promised that there would not be cuts to child protection staff in light of the Hughes inquiry, staff are still being cut. This is because positions are not being filled for those staff who resign and those who retire. Moreover, MCFD has also frozen funding for social workers that want to pursue ongoing education. This is unfortunate, as the above has illustrated the need for child protection workers to get more training to adequately work with their client’s complex needs.

Prevention

Bennett et al. (2009), further found that over half of social workers did not feel that their clients had access to adequate preventative service. Instead, children were removed from their homes and put into expensive foster homes instead of spending resources on supporting families (Bennett et al., 2009). MCFD receives calls on families but they are not given adequate attention because the call is not serious enough. Instead,

MCFD waits until things fall apart and then children end up being removed from their parent's care. Similarly, half of social workers in the above study felt that they did not have adequate resources for prevention (Bennett et al., 2009). This is detrimental to Aboriginal families, as over sixty percent of social workers working with Aboriginal families felt that there were not adequate services to meet their family's needs while only forty percent of social workers working with non-Aboriginal families did (Bennett et al., 2009). As a result, in order to reduce children coming into care and reducing recidivism in the child protection system, more resources need to be put into prevention, a much overlooked area in child protection.

The common practice for MCFD once they receive a report from the community that a woman is pregnant and may have an issue with illicit drug use is to send alerts to hospitals and close the file until she gives birth and then investigate once the child is born. Women are not offered support and there is no outreach to engage the expectant mother. Moreover a large number of these alerts contain information that is not true, as the social worker does not check the report out, but goes by the caller's information. When speaking with a Provincial After Hours social worker that receives a number of these alerts, she found that most alerts would describe the pregnant woman as "transient" or "chronically homeless." However, when she would check the woman's income assistance file, it would have an address and information that would lead to the conclusion that she has been in fact stable. Yet social workers do not check this information out and instead, go on the public's inaccurate construction of what a "crack whore" is and respond accordingly.

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When I was on a specialized team that worked with Aboriginal women where illicit drug use was an issue, we would do everything we could to find the woman and offer support services before the woman giving birth. This resulted in women in the community being informed about our team and coming to us on their own, as early as five months gestation in order to get services. Consequently, social workers need to do more with prevention by engaging women first as this results in fewer misunderstandings and prevents these women from being investigated for no solid reason. Reports about these women will continue to come from the community and MCFD as a result, has to open a file for every call they get. If more were done voluntarily before the baby was born, there would be less trauma for mom and baby after, as it would prevent an investigation occurring.

Engaging Men in Child Protection Practice

Social workers need better training on how to engage men in child protection social work, especially when they are resistant. This needs to be done in order to reduce overburdening mothers. This would include providing guidelines or developing special initiatives on working with fathers. Moreover, there needs to be a more articulate definition of what fathering is (Milner, 1993). Without this, the process of mother blame will continue and techniques on working with fathers will not be developed (Milner, 1993). Child protection files should also not be exclusively and arbitrarily under the mother's name and should include both mother and father.

Government also needs to acknowledge that not having a gender analysis is concerning because this affects how policy is made and what services are funded in child protection (Featherstone, 2003). MCFD's comprehensive risk assessment as well as

other documents like practice standards use gender neutral terms and yet, assessment and practice still focuses on mothers. Consequently, the role of fathers must be included in policies, which usually focus on the mother and how she can maintain the safety of her children. Moreover, there needs to be funding on resources that are for fathers. This is so because male discourse of what fatherhood is includes terms like, “provider” and “protector” and ideal fathers are described as “strong and controlled” (Featherstone, 2003, p. 304). Therefore, constructions of fatherhood continue to be surrounded by gendered stereotypes (Featherstone, 2003). What this ignores is the hardships that men will face as fathers that can create feelings of inadequacy, limited coping, and this could, in turn, to abuse or neglect (Featherstone, 2003). For example, it could lead men to escape their role as fathers because they feel that they don’t measure up to the idealized standard of what a father is. In Featherstone’s (2001) review on research on fathers in the child welfare system, she argues that for men to be more engaged in child protection plans, family centers and services must also have programs suited for fathers. This would also prevent overburdening mothers with an exhaustive list of services that they must do. Moreover, with more programs for fathers, they cannot make excuses that services are too woman centred and therefore, must access them.

Advocacy

I recommend all women who have children in government care to have an advocate present when meeting with MCFD in order to ensure MCFD expectations are clear, adequate visitation with their children is negotiated, and to make certain that children in care have a voice and are being cared for adequately. This is because, as the literature shows, the basic rights of mothers and children in care are not being met. The

Representative for Children and Youth (RCY) was created to become a watchdog over MCFD. However, women who participated in my study found these advocates to be largely unhelpful. They found them too busy and found that they did not show up for important meetings. Moreover, at my practicum experience, there was a child that was removed for no solid reason and RCY found that the basic rights of the child and family as outlined by MCFD standards were not being met. RCY also found that MCFD had breached the United Nations Declaration on the Basic Rights of the Child. This led RCY to write a formal complaint to MCFD as did the families' First Nation's community, however, MCFD ignored this and proceeded with the removal. Consequently, RCY needs to have more power in order to influence MCFD's practice when it has been found to be unethical. Furthermore, RCY needs more staffing so that they are able to adequately respond to every client. As of now, RCY only has one office in Burnaby for Metro Vancouver. Consequently, they need to have smaller and more offices and these offices should be in areas more accessible to impoverished clients.

A Call for Further Research

In order for these implications to be studied more exhaustively and for recommendations to be put into place, more research needs to be done on this issue. For example, research needs to be done comparing the outcomes for children in care versus the children that were supported on staying with their mothers when substance use was an issue. As more research on this topic is done and supports mothers, policy will need to catch up with research. Furthermore, a lot of the research published focuses on negative social work practice and therefore, research also should be done on social work practice that has worked well with this population. There also needs to be more research on

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involving fathers in child protection matters. Likewise, a needs assessment on services for fathers also needs to be pursued so that their needs are adequately met. In order for this research to take place, Canada needs to allocate more funding in studying this issue, as research in Canada is limited on this topic.

Summary

The lack of appropriate services for this population, long wait lists to access services, and the lack of collaboration in choosing services all result in children being in care for longer periods of time. Attitudes of social workers towards substance using mothers and their lack of education about the process of addiction also contribute to poor outcomes for this population. This is augmented by the fact that a risk assessment is used to determine if and when children are returned to their parents. This is concerning because research has established that risk assessments are poor predictors of future harm to children, due largely to the fact that the definition of abuse is a social construction and varies across time and place. The risk assessment and child welfare agencies also ignore the effects of structural issues such as poverty, colonization, racism, and gender inequality in contributing to perceived child neglect. In order to address this, child welfare workers need more training on addiction, including how to engage men in child protection practice. Strength based practice also should be standard practice, not just a theoretical construct that workers forget once after they graduate from university. Moreover, social workers need to be better supported so that they can form meaningful relationships with their clients. However, in order to reduce child welfare involvement with this population, more resources need to be allocated to prevention and more research needs to be done to on how better to serve this population from a child welfare standpoint.

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