Mothers with Newborns with Neonatal Abstinence Syndrome

Les Mère de nouveau-nés atteints syndrome d'abstinence néonatale

by

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Abstract

This advanced practicum thesis paper highlights my experience in a Master of Social Work (MSW) practicum at the Children's Aid Society in the Nipissing District (CASNPS). The report draws attention to theory and practice concerns and explores how to better align current practices with research. The work is dedicated to bridge the gaps of services for pregnant women, mothers with newborns with neonatal abstinence syndrome, and their children. The advanced practicum experience at CASNPS in early intervention services and child protection strengthened my knowledge of child welfare, and of existing gaps in services that affect the helping relationship with parents. Reflectivity guided my practice to identify some of my limitations as a social work practitioner and brought awareness to my privilege. It is my observation that the Children's Aid Society of Nipissing and Parry Sound has enriched families by implementing attachment theory in programming. The thesis identifies areas that can further assist families struggling with substance misuse by bridging child welfare concerns and helping empower parents. The thesis includes various forms of learning such as program shadowing, supervisory consultation, research participation, reflexive journaling, confidentiality training, case conferences with service users, internal meetings, individual case planning, and family home visits. The report concludes with reflections on the Canadian Association of Social Workers Code of Ethics, the implications for social work practice, and potential opportunities for the Nipissing District.

Résumé

La présente thèse met en lumière mon stage de perfectionnement effectué auprès de la Société d'aide à l'enfance du district de Nipissing et de Parry Sound dans le cadre du programme de maîtrise en service social. Ce rapport fait état de différentes préoccupations en rapport à la théorie et la pratique et explore comment mieux aligner les pratiques actuelles sur la recherche. Les travaux effectués visent à combler les lacunes des services destinés aux femmes enceintes, aux mères de nouveau-nés atteints du syndrome d'abstinence néonatale et à leurs enfants. Cette expérience pratique en services d'intervention précoce et de protection de l'enfance a renforcé mes connaissances en matière de protection de l'enfance et en ce qui a trait aux lacunes existantes dans les services affectant la relation d'aide avec les parents. La réflexion ayant guidé ma pratique m'a permis de définir certaines de mes limites en tant que praticienne du travail social en plus de me faire prendre conscience des privilèges dont je jouis. Selon mes observations, la Société d'aide à l'enfance du district de Nipissing et de Parry Sound a contribué au renforcement des familles en appliquant la théorie de l'attachement à ses programmes. La thèse précise les domaines ayant la capacité d'appuyer davantage les familles aux prises avec l'abus de substances en comblant certaines des lacunes soulevant des préoccupations en matière de protection de l'enfance ainsi qu'en aidant à habiliter les parents. La thèse fait également état de diverses formes d'apprentissage auxquelles on a eu recours dont l'apprentissage par observation, la consultation de supervision, la tenue d'un journal, la participation à des recherches, à de la formation en matière de confidentialité, à des conférences de cas avec des utilisateurs de services, à des réunions internes et à la planification de cas individuels, ainsi que la réalisation de visites de familles à domicile. En conclusion, le rapport propose une réflexion sur le code de déontologie de l'Association canadienne des travailleuses et travailleurs sociaux,

présente certains des enjeux en ce qui a trait à la pratique du travail social et examine des occasions possibles pour le district de Nipissing.

Definition of Key Terms

Buprenorphine Treatment Therapy (BUP)
An opioid medical replacement therapy.

Drug Addiction
The term drug addiction has been replaced by the terms of substance misuse and substance abuse, which are used interchangeably.

Kangaroo Care (KC)
Therapy techniques applied with infants who have NAS symptoms, which includes intermittent skin-on-skin contact.

Kangaroo Mother Care (KMC)
A therapeutic approach for mother-infant, skin-on-skin, 24/7 contact.

Methadone Treatment Therapy (MMT)
An opioid medical replacement therapy.

Neonatal withdrawal or **neonatal abstinence syndrome**
(**NAS**) is a withdrawal syndrome of infants after birth caused by in utero exposure to drugs of dependence

Opioids
Opioids is a class of drugs that are either illicit or prescribed and highly addictive. They include opium, heroin, codeine, oxycodone, hydrocodone tramadol, morphine, hydromorphone, fentanyl, and carfentanil (American Addiction Centers, 2019).

Pharmacologic Treatment
A treatment plan involving the administration of medication.

Non-pharmacological Treatment
A treatment plan that does not involve the administration of medication and relies on environmental conditions, human touch such as breastfeeding, skin-on-skin touch, and/or physical contact techniques of kangaroo care (intermittent skin-on-skin) and or kangaroo mother care (24/7 skin-on-skin).

Définition des termes-clés

Thérapie à la buprénorphine
Traitement de substitution aux opioïdes.

Toxicomanie
Le terme de toxicomanie a été remplacé par les termes mésusage de substances et abus de substances, lesquels sont utilisés de manière interchangeable.

Méthode kangourou
Techniques de thérapie appliquées aux nouveau-nés présentant des symptômes du syndrome d'abstinence néonatale, qui comprennent un contact peau-à-peau intermittent.

Méthode mère kangourou
Approche thérapeutique consistant en un contact peau-à-peau continu et prolongé, de jour comme de nuit, du nouveau-né avec sa mère.

Thérapie à la méthadone
Traitement de substitution aux opioïdes.

Syndrome d'abstinence néonatale
Syndrome de sevrage observé chez les nouveau-nés et associé à l'exposition intra-utérine aux opiacés et autres substances toxiques.

Opioïdes
Les opioïdes sont des drogues illicites ou d'ordonnance qui créent une forte dépendance. Parmi celles-ci on retrouve l'opium, l'héroïne, la codéine, l'oxycodone, l'hydrocodone, le tramadol, la morphine, l'hydromorphone, le fentanyl et le carfentanyl (American Addiction Centers, 2019).

Traitement pharmacologique
Plan de traitement ayant recours à l'administration de médicaments.

Traitement non pharmacologique
Plan de traitement n'ayant recours à aucun médicament et reposant sur les conditions environnementales, les contacts humains comme l'allaitement et le contact peau-à-peau, et les techniques de contact physique de la méthode kangourou (contact peau-à-peau intermittent) et de la méthode mère kangourou (contact peau-à-peau continu et prolongé, nuit et jour).

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I thank the service users of the Ontario Works program, Nipissing Transition House and the North Bay Regional Health Centre/Nipissing Detoxification Substance Abuse Programs, who have shared certain aspects of their lives and allowed me to listen, learn and understand their struggles. My employment in various institutions in the Nipissing District has allowed me to explore social problems from a grassroots lens of service users. Mostly, I thank you for sharing your journeys with me and giving me the privilege to hear your truths. You have inspired me to use this knowledge, and you have given me the strength and courage to continue my studies so that I can further explore how I can help families living in the Nipissing District. It is in hopes that other Northern communities, government bodies, policymakers, and organizations can come

together to hear the voices of lived experiences and adopt new initiative programming to meet the direct needs of individuals and their families that may develop from my journey.

I want to express my gratitude to my Advance Practicum supervisor Ms. Gisele Hébert, MSW, Executive Director of the Children's Aid Society of the Nipissing and Parry Sound Districts (CASNPS) for her mentorship, support and kindness. I want to thank my field Supervisor Deborah Brewer, Supervisor of Early Intervention & Family Support, for her knowledge, guidance, and clinical expertise. I want to extend my gratitude to Susan Baker, MSW, and Kim Robinson for their guidance, feedback and shared knowledge. I want to extend my appreciation to the Supervisors and staff at the Children's Aid Society for taking the time to include me in their day to day practice for my learning journey throughout my practicum.

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"The love of the family, the love of one person can heal. It heals the scars left by a larger society. A massive, powerful society"

"Nothing can dim the light which shines from within"

Maya Angelou

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Introduction

As an employee of the District of Nipissing Social Services Administration Board (DNSSAB) with a job title of Ontario Works Case Manager, I came to the MSW program at Laurentian University with experience working with victims of abuse, persons struggling with addiction, and mental health. My passion lies in working with young families. I wanted to understand social problems from a different perspective and context. I have had multiple workplace experiences, which included the Nipissing Transition House, a home for women and children fleeing abuse, and the North Bay Regional Health Centre/Nipissing Detoxification Substances Abuse Programs (NBRHC/NDSAP), a safe place for individuals seeking substance misuse services.

My practicum took place from October 8, 2019, to January 7, 2020, at the Children's Aid Society of Nipissing and Parry Sound (CASNPS) located at 433 McIntyre Street West, North Bay, Ontario, 471 Main Street West, North Bay, Ontario, and 457 Main Street West, North Bay, Ontario. Within my Advanced Practicum, I wanted to learn more about how mothers with substance misuse and their infants are supported by the Children's Aid Society (CAS). My learning goals included:

1. To learn more about the policies and legislation that affect the population involved with the Children's Aid Society and how each step is critically assessed and measured. In conjunction with this I also wanted to further my knowledge of child welfare issues and the gaps in services that may affect the helping relationship with parents.
2. To include reflexivity in my advance practicum to recognize my limitations and/or areas of understanding that could further be explored. Reflexivity will help me become critical in my thinking and help bring awareness to my work. Baskin (2016) reiterates that social

workers are helpers or warriors, and the teachings encourage self-reflexivity and self-care as this provides a way for healing. Journaling was done weekly and included learnings, observations, areas of identified weaknesses, and areas of development through engaging with the research literature.

3. To learn more about how to alleviate the oppression faced by parents involved with the CAS and how to empower parents.
4. To learn how the CAS implements attachment theory in their policies and procedures, mandate, and guidelines. To further my understanding of how the CAS operates from an anti-oppressive approach.
5. To gain a better understanding of the funded programs offered to families by the Children's Aid Society in the District of Nipissing and to strengthen my current understanding of community resources within the district.
6. To understand how CAS assists families struggling with addiction and child welfare concerns.
7. To understand how the Indigenous population's needs are met with cultural sensitivity and see how the organization works towards the decolonization of Indigenous peoples within the child welfare system.

Chapter Summary

Chapter 1 provides a review of addictions and their effects on individuals, families, and communities focusing on the impacts on the mother's health and newborn child experiences. This chapter will include the theoretical framework of attachment theory, strength-based theory and empowerment theory, discuss anti-oppressive practice (AOP) and challenges to implementing AOP, and review decolonization. Chapter 2 offers an overview of my advanced

practicum environment and aspects of my practicum along with a description of my social location. Chapter 3 connects theory to practice by reviewing child welfare engagement in attachment focus, strength-based approaches, empowerment and anti-oppressive practice. Chapter 4 explores how child welfare can better serve women with children and reviews residential programming and support for mothers using substances. This chapter will provide details of an Ontario housing model and bring awareness to existing gaps leading to the provision of recommendations. The final chapter provides critical reflection of the advance practicum to include self-care, identifying organizational strengths, gaps, future opportunities, implications for social work practice, and future study and opportunities.

Chapter 1

Literature Review and Theoretical Framework

Literature Review of Substance Use and Child Welfare

Addictions to food, alcohol, gambling, and drugs have been linked to early trauma. There are several different causes and factors in the development of addictions, such as genetics, social, and psychological (Mate, 2015; Sinha, 2008). Abuse of substances may negatively impact one's overall life through stunting developmental needs, impairing attachment, economic hardship, emotional distress, legal problems, and potentially place one at risk of violence (Lander et al., 2013).

There has been an increase in opioid addiction in Ontario (Dow et al., 2012), and more specifically, in Northeast Ontario (Batfour-Boehm et al., 2014) as well as the United States (Detweiler & Ward, 2015; Terplan & Minkoff, 2017). Due to intergenerational trauma and the ongoing impacts of colonization, higher rates of addiction are widespread in Indigenous communities (Batfour-Boehm et al., 2014). Rural Indigenous communities have experienced higher levels of narcotic abuse, with First Nation communities having two to five times the rate of overdose deaths (Kiepek et al., 2012). Gomes et al. (2014) conducted a longitudinal, 20-year study examining opioid-related deaths in Ontario from January 1, 1991, to December 31, 2010. Their results of 5935 opioid-related deaths with a mortality rate increase of 242% from 1991 to 2010. The study also identified that one in every eight opioid-related death are between 24 – 34 years of age.

In 2018, in Canada, there were 4604 opioid-deaths, 94% of which were unintentional overdoses. Of these, 1471 deaths were in Ontario (Health Canada, 2019). Approximately 72% of accidental deaths are by males, where approximately half are between 25 - 44 (Ontario Agency

for Health Protection and Promotion (Public Health Ontario), Office of the Chief Coroner, Ontario Forensic Pathology Service, Ontario Drug Policy Research Network, 2019). One-third of the deaths (31.8%) are among people struggling to meet basic needs, such as having resources and services, where 46.8% were unemployed, 18.1% were employed, and 32.9% had an unknown employment status (Ibid, 2019). There were 10 documented opioid-deaths from July 2017 to June 2018 in the District of Nipissing and Parry Sound (Ibid, 2019).

The Northern Ontario Health Equity Strategy Report (2018) acknowledges the needs of individuals and families living in Northern communities. There is recognition of current gaps in services, a lack of resources, opportunities, and supports. Northern communities have higher suicide rates, and higher rates of illnesses associated with social determinants of health such as diabetes and cancer (Health Quality Ontario, 2018).

Increasingly, infants are directly affected by addictions and substance use (Dow et al., 2012). Northern Ontario has the highest numbers of infants with Neonatal Abstinence Syndrome (NAS); a term for a group of symptoms experienced by newborns that is associated with withdrawal from exposure to narcotics (Mental Health, and Addiction Scorecard, and Evaluation Framework MHASEF Research Team, 2015; The Ontario Educational Communications Authority (Sheikh, 2016, January 16). There are higher numbers of babies born with NAS in North West Local Health Integration Network communities where the mothers reside in low-income areas (MHASEF Research Team, 2015). Mothers under the age of 20 who deliver their first child are five times more likely to have a child with NAS than older women having their first child (Mental Health, and Addiction Scorecard, and Evaluation Framework MHASEF Research Team, 2017). The North East LHINs' communities are vulnerable due to being at a

social disadvantage for mental health and addiction services to child and youth mental health (MHASEF Research Team, 2015).

Child welfare services are mandated to protect children from physical, psychological, sexual, and emotional abuse and neglect. The service provided by child welfare workers is critical to families, as the overall mandate is to ensure children are in a safe environment. Ideally, child welfare workers focus on the child's best interest, providing resources to build parenting skills and build upon their knowledge base, and they have the power to apply child protective measures, which have significant impacts on families (Canadian Association of Social Workers, 2018).

According to the Canadian Association of Social Workers (2018), child welfare services should practice with individuals, families, groups, and community using ecological and strength-based perspectives, informed by developmental theories and incorporate a permanency planning orientation, while employing "cultural sensitivity," "competence," and engage in "collaborative approaches" (p. 12). In Ontario, The Child, Youth, and Family Services Act (2017) establishes the parameters of child welfare measures for children under the age of 16 and Voluntary Youth Service Plan for those 16 - 18 years of age (Ibid, 2017). Children's Aid Societies are sanctioned with the authority to provide child welfare services in the province of Ontario (Ibid, 2017).

Mothers Who Use Substances

This section will explore mothers' strengths, bring awareness to the role of motherhood, offer meaning to the mother-child dyad, identify areas of mother blaming, examine resilience when faced with adversity, and review recommended approaches to care when working with this marginalized population. There is significant strength in the population of childbearing women in the Nipissing District but a lack of research on these strengths. Mothers' strengths are

important to acknowledge as they are often overlooked and underutilized. A Canadian study with Indigenous mothers who use substances identified strengths related to hope and mothering (Shahram et al., 2017). Family, partner, peers, culture, spirituality, and mentor relationships were found to provide strengths to mothers as they juggle multiple roles and healing from traumatic lived experiences (Shahram et al., 2017). This marginalized population was described as socioeconomically resourceful in meeting their family's needs. Sandelowski and Barroso (2003) describe mothers with human immunodeficiency viruses (HIV) as having the inner strength of hope and esteem when raising their children. In this study, motherhood strength derived from providing care to their family. Mothers are described wanting to be viewed as a good mother, supportive parent, and engaged in the mother-child relationship.

For many women, our role in society remains gendered, and there are expectations of fulfilling duties that are gender-focused, including bearing children, child-rearing, and household duties such as cleaning, cooking, and shopping. These gender prescribed roles have drawbacks. Baines (2011) describes women's work as multiple jeopardy, where mothers are expected to work full-time inside and outside the home, often referred to as public and private spheres. Hays (1996) introduced the concept of intensive mothering, which is "child-centered, expert-guided, emotionally absorbing, labor intensive, and financially expensive" (p. 46). This implies that women are the primary caregivers of all aspects of children's wellbeing and causes unrealistic expectations for mothers (Henderson et al., 2015). Henderson et al. (2015) hypothesize heightened psychological feelings of the pressure of not being the perfect mother or guilt for not meeting expectations that result in high levels of stress and anxiety with low self-efficacy. This imposed responsibility negatively impacts women's lives today with unrealistic challenges and unattainable standards of perfection (Henderson et al., 2015; O'Brien Hallstein, 2006).

In Western society, motherhood is rooted in "…child development, family development, male-female relationships, women's roles in society, and the economic and social climate of the cultural environment" (Sommerfeld, 1989, p. 15). When a mother does not measure up to Western societal expectations of what constitutes a "good mother," we engage in mother blaming (Sommerfeld, 1989) and withhold sympathy for those that fail to meet often unrealistic and unattainable expectations (Greaves et al., 2002) subsequently labelling them a "bad mother."

Mother blaming is embedded in substance-using pregnant women and mothers, victims of abuse, and mothers who struggle with mental health (Greaves et al., 2002). With substance-using pregnant women, in particular, mothers are scrutinized for not protecting their fetus, and when they seek help, they are further scrutinized for their capacity to mother (Greaves et al., 2002). Mother blaming is reinforced in child protection work (Fine & Mandell, 2013). When violence occurs in the family home, the child is viewed as the victim rather than the child and mother, which causes the mother to be viewed as unfit to protect her child (Greaves et al., 2002). Mother blaming is also predominant for mothers who struggle with mental health as they become a target of surveillance or are viewed as unfit unless they have community supports (Greaves et al., 2002). These are stigmas that haunt and belittle women's mothering. Labels and stigma may also result in a self-fulfilling prophecy for some mothers. A mother's experience of "…guilt, stigma and shame…" is compounded by others' "…judgement, blame and unsympathetic…" notions that affect a person's ability to influence their actions due to fears, self-doubt, and defeat (Greaves et al., 2002, p. 6).

Resilience is the ability to move through challenges or adversities and recover when faced with stressful situations (Moriarty et al., 2011). Mothers who struggle with substance misuse have strength and resilience (de Boer & Coady, 2007) as they have the ability to cope and work

through child welfare expectations when a helping relationship is developed (de Boer & Coady, 2007). Part of being resilient is to have mentorship through peer support to connect with other mothers with similar experiences thus creating social supports, inclusion and hope for recovery (Paterno et al., 2019). A valuable source of information is the sharing of stories by mothers in Mothercraft's Breaking the Cycle (BTC) program (Racine et al., 2009). This program follows a women-focused approach where theory is incorporated into programming to support mother and child that meets health-related and the social determinants of health needs of pregnant women and women struggling with substance misuse in Toronto, Ontario (Racine et al., 2009). Marcellus et al. (2015) supports the programming that is focused on maternity care, community based, and meets the desired needs of this population. A women-focused approach to programming provides a resourceful, strength for families and goes beyond traditional type health services that can be considered "a one stop shop" where, such as the BTC, provides an environment that is a safe place for women who experience poverty, trauma, and substance misuse to feel supported and connected (Marcellus et al., 2015).

Pregnant women and mothers using substances struggle with stigma, fear of judgment, unplanned pregnancies, and have many unanswered questions regarding their unborn child (Dow et al., 2012). Pregnant women who misuse substances face various challenges; parental support and guidance can develop hope for their futures and motherhood (Sodorstrom, 2011). It is essential to communicate with this population in a kind, non-judgmental way to empower her ability to see her self-worth and gradually build on her desire to care for her health and the health of her child (Racine et al., 2009). The helping relationship will help support the mother when provided services that are respectful with a "mindful, and judicious use of power" and "humanistic attitude and style that stretches traditional professional ways-of-being" (de Boer &

Coady, 2007, p. 35). It is essential to support pregnant mothers with substance misuse emotionally, psychologically, and physically as this will help improve outcomes for the mother and her child (Sodorstrom, 2011). When the support provided is non-judgmental, the relationship between service providers and pregnant women or mothers struggling with substance misuse is stronger (Gendering the National Framework, 2010).

Impact on the mother's health

Two-thirds of women who struggle with substance misuse also struggle with other challenges such as trauma, abuse, and mental health concerns (Cormier et al., 2004). Women who have been the victim of abuse are more likely to experience post-traumatic stress disorder, depression, anxiety, suicidal behaviour, and low self-esteem (Cormier et al., 2004). Mate (2015) suggests that families with generational trauma are predisposed to diseases such as illnesses related to mental health (depression and psychosis), addictions, and cancer (Mate, 2015). Indigenous communities experience health problems with higher levels of alcoholism, violence, obesity, diabetes, and overdose deaths (Gracey & King, 2009). Illnesses such as mental health, addiction, and cancer are more prevalent in the lives of individuals who experience early life challenges (Fuller-Thomson & Brennenstuhl, 2009; Mate, 2015). Mate (2015) emphasized that the human brain is affected by life challenges such as being exposed to high levels of stress, living through trauma, being deprived of economic needs, and not being socially accepted. This places vulnerable people at a disadvantage, which shifts to behavioural problems, learning challenges, and mental health challenges. Oppression, racial, and ethnic inequalities bring about social despair and insecurity, causing stress, which, in turn, brings about health problems (Mate, 2015).

It is recommended that pregnant women who identify with Indigenous heritage should be supported through cultural sensitivity and through building community partnerships (Dow et al., 2012). An example, if appropriate, is to link family members to supports that are of Indigenous focus where cultural and spiritual ceremonies are available to help with healing, such as having access to a sweat lodge, smudging, and healing circles (Baskin, 2016). Learning environments that are provided with care and without judgment, encourage participation by mothers (Kocherlakota, 2014). In this placement, providing empathy and emotional support and connecting appropriate community resources to families within the Nipissing District is fundamental to support wellness and healing. It is important to be familiar with all programs in the Nipissing and Parry Sound District to help with the success of families. Women, in general, should be able to access services to best help herself and her child to succeed in life (British Columbia Centre on Substance Use, 2018).

Neonatal Abstinence Syndrome

Neonatal Abstinence Syndrome is the result of in-utero substance exposure and is the term used to describe infants' withdrawal from a substance (Tolia et al., 2015). Neonatal Abstinence Syndrome affects the newborn's central nervous system and digestive system, causing significant pain and discomfort (Kocherlakota, 2014). Symptoms include excessive crying, stiffness of the neck, hyperthermia, irritability, seizures, diarrhea, tremors, sweating, sneezing, weight loss, yawning and disordered sleep (Dow et al., 2012; Ebner et al., 2017; Kocherlakota, 2014). These infants often struggle to self-soothe and are agitated (Kocherlakota, 2014). In Canada, the majority of hospitals measure NAS symptoms by using the Finnegan Neonatal Abstinence Scoring System (Dow et al., 2012; Filteau et al., 2018; Kocherlakota, 2014;

Wong et al., 2011), which is a measure of the infants' symptoms to determine the level of discomfort due to withdrawal from a substance.

When an infant has NAS, there are various ways to support the child. The therapy that is the least expensive and less contentious is a non-pharmacologic treatment, which includes swaddling, having dim lights, low noise environment, avoiding certain rocking styles, and ensuring not to wake the child if sleeping (Kocherlakota, 2014). Supportive care to both mother and infant promotes bonding and can help avoid pharmacology therapy (Kocherlakota, 2014). For more adverse NAS symptoms pharmacology techniques are required (Dow et al., 2012). The most critical aspect of infants with NAS is having direct contact with their mother as this interaction helps decrease NAS symptoms (Pritham, 2013). Moore et al. (2012) recommend skin-to-skin contact of infant-mother after birth where the infant is placed on the mother's chest. Early skin-to-skin touch is associated with cardio-respiratory stability, decreased infant crying, and has benefits supporting breastfeeding, and significant for infant-mother attachment (Moore et al., 2012). Skin-on-skin contact of infant-mother is recommended after delivery, which initiates successful breastfeeding (McQueen et al., 2015).

Kangaroo Mother Care (KMC) is 24/7, non-pharmacologic, skin-on-skin care that is a recognized best practice care option for infants as it promotes health and development and is practiced in Columbia, Sweden, Brazil, Germany, and Madagascar (Ludington-Hoe, 2011). Kangaroo Mother Care is recommended when skin-on-skin contact is provided intermittently (Dow et al., 2012; Kocherlakota, 2014; Ludington-Hoe, 2011; Pritham, 2013). Kangaroo Mother Care is considered therapy that helps the physiologic effects such as infant heart rate, respiratory, temperature, metabolic, brain maturation, and brain complexity (Kocherlakota, 2014).

Specifically, these physiologic effects help promote lactation, ease pain, and lessen crying and agitation (Kocherlakota, 2014).

Kangaroo Mother Care reinforces mother-child attachment and is an essential part of establishing a breastfeeding relationship (Ludington-Hoe, 2011). Breastfeeding creates an infant-mother bond, which supports secure attachment (Lindemalm et al., 2009). Breastfeeding is also endorsed for NAS infants as it supports mother-infant attachment and has simultaneous benefits of breastfeeding and non-pharmacologic treatment (Ludington-Hoe, 2011; Tolia et al., 2015). Breastfeeding lowers the amount of needed pharmacological therapy (Detweiler & Ward, 2015; Dryden et al., 2009). Emerging evidence finds that Kangaroo Mother Care and breastfeeding contribute to shorter hospital stays and aid in lowering NAS symptoms (Detweiler & Ward, 2015; Dryden et al., 2009; Hayes & Brown, 2014; Ludington-Hoe, 2011).

Breastfeeding infants, when the mother has substance misuse, is a controversial topic for many health and social care providers (Lindemalm et al., 2009). It is vital to have mothers be engaged and encouraged to partake in breastfeeding and treatment that is not compromised by discrimination, stigmatization marginalization and is supportive for families and community (Terplan & Minkoff, 2017). For many years it was not recommended to breastfeed if mothers were on methadone treatment of more than 20 ml per day (Lindemalm et al., 2009). Lindemalm et al. (2009) support breastfeeding and suggest that the breastmilk of mothers who are on Buprenorphine (BUP) or other opioid treatment gives low exposure to the infant but does require monitoring. When the mother is taking opioid replacement therapy (methadone, buprenorphine treatment), a small amount is passed to the infant that aids in alleviating NAS symptoms (Detweiler & Ward, 2015; Dow & et al., 2012; Dryden et al., 2009). The higher the methadone dose, the higher the level of NAS symptoms (Dryden et al., 2009). Notably, mothers can

breastfeed if they have Hepatitis C (Kocherlakota, 2014). This is due to a low to no mother-child-transmission of the Hepatitis C virus (European Paediatric Hepatitis C Virus Network, 2001).

Methadone treatment is the standard care for pregnant women struggling with opioid addiction, while another identified treatment is Buprenorphine (Dow et al., 2012; Kocherlakota, 2014). However, buprenorphine is not available in Canada unless sought through special permission, during pregnancy, through Health Canada's Special Access Program (Wong et al., 2011). Buprenorphine can be found in Suboxone, which is combined with Naloxone; however, there is limited information about Suboxone use during pregnancy (Wong et al., 2011). If the mother is on an opioid treatment program, she is encouraged to breastfeed unless she is HIV positive (Dryden et al., 2009; Kocherlakota, 2014; Lindemalm et al., 2009; Simard, 2019), using illicit drugs (Dow et al., 2012; Lindemalm et al., 2009) and using or street drugs, or polydrug (Kocherlakota, 2014). Illicit drugs are a controlled substance, including lysergic acid diethylamide (LSD), ecstasy, heroin, cocaine, crack, crystal meth, and ketamine (Lankenau et al., 2012). Opioids is a class of drugs that are either illicit or prescribed, and highly addictive. They include opium, heroin, codeine, oxycodone, hydrocodone tramadol, morphine, hydromorphone, fentanyl, and carfentanil (American Addiction Centers, 2019).

Neonatal Abstinence Syndrome symptoms are monitored and measured on a 3-4 hour interval; medication is provided after feedings to help ease the pain of withdrawal symptoms (Kocherlakota, 2014). The literature refers to various hospital administered drugs to treat NAS, but the most effective medication with infants is morphine (Dow & et al., 2012; Dryden et al., 2009; Ebner et al., 2017; Kocherlakota, 2014; Simard, 2019). Morphine is known for its quick recovery from withdrawal symptoms (Ebner et al., 2017), but still requires a weaning period

(Kocherlakota, 2014). Clonidine has also been utilized but lacks research (Kocherlakota, 2014). Phenobarbital is also used but only when using methadone and or morphine (Kocherlakota, 2014). In the United Kingdom, phenobarbital is a secondary medication administered after morphine for NAS (Dryden et al., 2009). In the United States and Canada, morphine and phenobarbital are used (Disher et al., 2019). The most common medication used in the United States to treat NAS is methadone (Kocherlakota, 2014). The long-term effects of NAS are not entirely known, and an ongoing assessment of the child is recommended (Dow et al., 2012). Kocherlakota (2014) suggests that NAS infants be monitored for neurodevelopment, behavioural, and vision assessments, and be provided with family support to "exclude continuous maternal substance abuse and child abuse" (Kocherlakota, 2014, p. 555).

Theoretical Framework

Many theories and intervention modalities can be applied to promote the therapeutic relationship. Child protection workers, in particular, apply various theoretical approaches that aid in the client's desired outcomes. The practicum included working from the perspective of structural social work within the context of child welfare (Mullaly, 2007; Mullaly & West, 2018). Structural inequalities create socioeconomic factors that affect certain groups more so than others in society (Mullaly, 2007; Mullaly & West, 2018). Disempowered populations are plagued by social issues such as poverty, lack of housing, addiction, mental health, and systemic racism. Inequality within social structures contributes to social problems creating significant impacts on families; socially, financially, health, environment and, in turn, a great indicator of the determinants of health (Mullaly & West, 2018). The placement provided opportunities to gain insight into individual and family needs and link them to appropriate community resources and or services. From a structural social work practice approach, there are six actions of

empowerment: 1) help client obtain resources; 2) work on removing power relations in the client-worker relationship; 3) help identify the structures of oppression; 4) provide awareness; 5) participate and promote social movement/social justice; and 6) move the client to accept their feelings and actions, work to change on a personal level, and to foster political movement (Mullaly, 2007).

Attachment Theory

Attachment theory explores the relationship of the child-mother and/or primary caregiver (Ainsworth, 1979). Attachment theory is a psychodynamic theory applied in social work practice (Wang & Stalker, 2017). Psychodynamic theorists assert that the caregiver-infant relationship has significant importance and plays a vital role in child development outcomes **(**Zeanah et al., 1989). Bowlby (1969) developed attachment theory to understand parental relationships, and how environmental contributions help shape a person's characteristics. Bowlby also focused on the deprivation of the child and mother relationship contributing to mental health (Blakely & Dziadosz, 2015). It was his belief that a person's mental health was affected by their attachment early on in childhood development (Blakely & Dziadosz, 2015). The relationship developed is related to the secure base created by the child-mother and measured by the ability to adapt to separation and to explore new surroundings (Levy et al., 2011).

Mary Ainsworth built upon Bowlby's framework and identified three patterns of attachment: secure, avoidant, and ambivalent (Ainsworth, 1979). Ainsworth's contribution stems from her research of the Strange Situation Protocol, where she observed the relationship between child-mother or primary caregiver in an attempt to understand separating and reuniting (Ainsworth, 1979). Ainsworth's contribution to attachment theory emphasized the importance of the mother-child bond within the first year of life as it was understood to shape future child

development. Ainsworth focused more on the coexisting relationship of the mother-child dyad as opposed to relying on the child's behaviours for answers (Rosmalen et al., 2015).

Mary Main and colleagues developed a fourth attachment style: disorganized (Main & Solomon, 1990). Avoidant, ambivalent, and disorganized are patterns of insecure attachment with the primary caregiver due to abusive caregiving displayed by inattentive, unemotional care and/or neglect (Mennen & O'Keefe, 2005).

For an attachment theorist, *secure attachment* is understood by the result of a nurturing and caring relationship with the primary caregiver (Mennen & O'Keefe, 2005). When children have a secure attachment, they have a primary caregiver who responds to their needs (Mennen & O'Keefe, 2005). The children of secure attachment can participate in interpersonal relationships, where they feel comfortable to explore new things and new environments (Mennen & O'Keefe, 2005). *Avoidant attachment* is characterized by inconsistent caregiving and can be wrathful (Wang & Stalker, 2017). This is the maternal rejection and hostility of persistence of unresponsiveness of attachment needs (Finzi et al., 2000), or irregularly responds to child's emotional needs (Mennen & O'Keefe, 2005). As a result, the child shows signs of distrust of the primary caregiver and disproportionately self-reliance. In times of distress, the child is distant and acts as though they do not need the caregiver (Mennen & O'Keefe, 2005).

A child with *ambivalent attachment* is described as showing signs of dependency and has angry outbursts towards their primary caregiver when they experience distress (Mennen & O'Keefe, 2005). The child monitors the primary caregiver's whereabouts, often spends time alone independently, or has behaviours of clinging and exhibits signs of separation anxiety (Mennen & O'Keefe, 2005). This set of behaviours is associated with a parent who is inconsistent, who may threaten abandonment, and/or be utilized as a control tactic (Mennen &

O'Keefe, 2005). *Disorganized* attachment is described as including child behaviours of avoidance, anger, and disorientation (Mennen & O'Keefe, 2005). Disorientated behaviour is associated with a primary caregiver who promotes fear (Mennen & O'Keefe, 2005). These children struggle with not knowing what the appropriate behavioural responses are and hence, cannot connect with the caregiver (Mennen & O'Keefe, 2005).

There is significant empirical evidence that supports attachment theory (Rosmalen et al., 2015; Wang & Stalker, 2017; Zeanah et al., 2011). Attachment theory provides a framework for child and parent relationships and fosters strength in resilience in adulthood. Erozkan (2016) suggests that childhood traumas stimulate the development of insecure attachment where emotional requirements are not met. For example, emotional abuse experienced as a child has signs of insecure attachment in adulthood and may result in impaired attachment with adult partners (Erozkan, 2016). Erozkan (2016) identified the relationship between childhood trauma and insecure attachment of those participants with increased sexual abuse, and physical and emotional abuse and neglect. Finzi et al. (2000) study suggests avoidant attachment of physical abuse is intergenerational, where there is a likelihood of later violent relationships in adulthood.

Whereas, in practice, attachment emphasizes the growing bond between mother and child provided that relationship continues to be nourished and supported for the provisions of healthy child development, mentally, psychologically, spiritually, and physically. When working with high-risk cases with signs of insecure attachment, it is crucial to help families reconnect with each other (Wang & Stalker, 2017). Child welfare workers may apply the attachment framework as a guide in decisions relating to child protection measures (Mennen & O'Keefe, 2005). Wang and Stalker (2017) argue the theory is strength based and takes environmental factors into account, which also supports the relationship between the worker and client.

Mennen and O'Keefe (2005) provide a case example of how attachment theory principles apply in child welfare matters. If a child needs removal from their home, they would be placed in a familiar home such as with a grandparent or a close relative, which is the least intrusive change. In order to help children who face adversities, it is fundamental to support the framework of attachment theory, which promotes child development in cognitive functioning and behavior self-regulation adaptation to meet the needs of children to enhance the quality of attachment through a mentorship role of an adult (Atwood, 2006). If the child returns to the parent's home, they are encouraged to maintain ongoing communication/visits with the alternate caregiver. If returning home is not feasible or safe, the child will be returned to the alternate caregiver. The example provides an understanding of how attachment theory is applied in practice.

Washington (2008) criticizes attachment theory for the culturally biased assumptions that guide the theory such as an overemphasis on the mother-child dyad, at the exclusion of the role for other caregivers and community. Attachment theory is created under a framework of white western values and does not take into account the culture of Indigenous peoples (Choate et al., 2019). When we refer to "whiteness" or "other whiteness" we are talking about the dominant culture; white, middle-class, social workers, or academics that impose a value or belief on a population understood as "other" and thus defines what constitutes a good parent (Choate et al., 2019). Choate et al. (2019) further explain that attachment theory applied to Indigenous people is discriminatory in child protection practice and pose additional harm to families who are underprivileged and who struggle socioeconomically. Child welfare decisions may not take into account the importance of a child's heritage of being placed in the same cultural environment or the essential connections of extended family, community, land, and spirituality. Choate et al.

(2019) explored the 1983 Supreme Court of Canada Racine v Woods case where bonding and attachment were considered the best interest of the Indigenous child rather than the cultural connection. Simard (2019) identifies that the attachment framework had undesirable consequences to First Nations families concerning child welfare services when children's heritage, language and culture were ignored. Further, the circles of care in aboriginal cultures include parents, peers, extended family, and their community (Muir & Bohr, 2019).

From a feminist perspective, attachment theory is often criticized for its emphasis on the primary caregiver, mainly women. The approach has been described as "mother blaming" (Washington, 2008, p. 10). Historically, women are assigned gender roles, which are reinforced by the patriarchal state where the primary responsibility of the family, such as nurturing children, falls on women. Child development and/or child experiences become the women's domain, which focuses on the responsibility of the mother when something goes wrong or when a child protection investigation is opened. Battered women, in society, are disempowered in their environments, including the power struggles within the family (Smith et al., 1995). Social workers need to exercise caution when working with mothers and focus on creating a therapeutic relationship that empowers change and encompasses the child and mother's needs. Importantly, by endorsing that all abused children or dysfunctional homes create generational dysfunction implies irreversibility of change (Allan, 2004).

Attachment theory has been well documented and explored in evaluating child-mother or primary caregivers' level of bonding. While it is beneficial to understand various aspects of attachment theory, the limitation of this framework reminds the reader to use it as a guide, and that critical thinking is required when making decisions around child protection matters. Wang and Stalker (2017) point out that when a secure attachment has not been fostered, the family

needs to work at understanding the multiple layers affecting the proper development of attachment and help support the child and caregivers to build a secure bond.

Strengths-Based Theory

Strength-base theory is referred to as a metatheory for direct social work practice and is a framework that explains past and present awareness (Witkin, 1991). Social workers that employ a strengths-based approach look for strengths in humanity to endow personal and societal change (Simmons et al., 2016). Strength-based theory meanings are described as a metatheory as they encompass the primary tenets of social work practice (Simmons et al., 2016). Within this review, we will explore the theory's strengths, critique, and its application to social work practice.

Strength-based theory looks at the resources and capabilities of a person, if they can meet their challenges, and work towards overcoming hardships (Simmons et al., 2016). Strengths-based social workers help strengthen a person's ability, increase social networks to bring about positive changes such as knowledge and resources to foster hope to help reduce symptoms of problems and to help address social problems to improve the well-being of the individual and the family (Simmons et al., 2016). Individuals are helped to identify areas of growth, recognize where to change, and rely on the resources in their environment, which are their strengths (Graybeal, 2001).

The therapeutic relationship relies heavily on communicating personal choice and knowing the desires and hopes of the service user, which help foster change within their lives, creating a sense of ownership of that change (Simmons et al., 2016). The strength-based social worker asserts that all traumas faced by individuals and families can, in turn, be used to find opportunities to heal and move forward with the help of therapeutic tools and/or resources within their community (Simmons et al., 2016). Problems are viewed as areas of opportunity for growth

and learning adaptive skills and building on resilience (Simmons et al., 2016). The relationship interaction includes learning how to cope in stressful situations but also to learn new coping skills provided in a non-judgmental learning environment (Simmons et al., 2016). The therapeutic relationship does not limit a client's ability to learn, grow and change within their environment (Simmons et al., 2016). By ignoring a client's potential to overcome challenges will help clients to overcome their doubts and help them see themselves beyond a prescribed limitation (Simmons et al., 2016).

Simmons et al. (2016) emphasize three critiques of strength-based theory. Strength-based theory ignores real problems by excessively concentrating on strengths (Simmons et al., 2016). Saleebey (1996) suggests by using this method, it appears as a positive thinking style that downplays real problems. For example, when we focus on the positive things in a person's life, it reduces attention to serious presented issues (Simmons et al., 2016). Saleebey (1996) suggests that when clients receive social services (welfare and mental health), they have been doctrine to see themselves as "deficient and needy," therefore more challenging to focus on strengths (p. 302). Second, the theory "lacks conceptual clarity" (Simmons et al., 2016, p.149). There is no clear definition to be applied consistently and has concerns about its application in social work practice (Rapp et al., 2005; Simmons et al., 2016). For example, there is no clear direction to apply strength-based theory. It lacks guidance on how it is identified, defined, or worked toward (Simmons et al., 2016). A third critique refers to the lack of empirical evidence to support this approach (Gray, 2009; Simmons et al., 2016). The theory is difficult to apply and measure, therefore the effectiveness of the intervention cannot be measured or justified (Simmons et al., 2016). There is no evidence to suggest that clinicians who use this model are more effective than those who do not (Simmons et al., 2016).

Gray (2009) provides a critique of strength-based theory as viewing the approach as etched within a neoliberal paradigm that focuses on individual responsibility. From a community development lens, the theory fails to take into account structural inequalities such as race, class, mental illness, and poverty; it promotes a political agenda on the backs of socioeconomically dependent individuals, families, and mostly women who bear the burden (Gray, 2009). Gray (2009) asks social workers to consider a holistic, strengths-based approach that emphasizes social justice and empowerment rather than simply solution focused approaches that emphasize choice, independence, and self-reliance.

Empowerment Theory

Empowerment theory is the heart of social work, as it has been described as a fundamental technique applied in practice (East, 2016). Empowerment theory is defined "as an increase in power in intrapersonal, interpersonal, and community realms" (East, 2016, p. 373). Empowerment in practice is the ability to help guide the learning of new ideas, to enhance the quality of life of an individual and or family to instill new desires, hope, resilience, and acceptance while moving towards adopting new opportunities that instills happiness, and stillness within their own accomplishments and life. An empowerment approach is used to increase a person's worth to increase interpersonal needs, where connection brings about concern for social justice movements, and striving to live together in harmony with self, families, and our growing communities (Hare, 2004). Empowerment is social justice that encompasses "inclusivity, equality and understanding oppression" (East, 2016, p. 373). The process of empowerment is comprised of power sharing, consciousness raising, and partnership (East, 2016). With an emphasis on self-efficacy, the approach is understood to increase a person's

power or resources and thus aims to have a positive influence in other areas of life such as relationships and in the sociopolitical sphere (East, 2016).

The theory recognizes the structural inequalities that affect one's life personally (East, 2016). Empowerment focuses on people's well-being, where knowledge and skills help to make sense of one's environment (Perkins & Zimmerman, 1995). The primary focus of empowerment theory is empowering individuals and linking this with social justice and political movements towards inclusiveness (East, 2016; Perkins & Zimmerman, 1995). The approach encompasses the dimensions of a person's situation based on social, political, and economic factors that affect oppressed persons in society (East, 2016). A social worker may help service users adapt to change and bring about new opportunities by changing their environment to meet individual needs (Mullaly & West, 2018).

Empowerment theory is connected to the social work values of supporting people to work towards self-actualization (East, 2016). Amplifying someone's power is an additional strength to the theory as it is rooted in encouragement towards change and development (East, 2016). East (2016) refers to the interconnectedness, defined as looking at the world from three levels; micro: dealing with self and families, mezzo: working with groups and communities, and macro: focusing on many communities, counties and global connectedness (East, 2016).

Empowerment theory can be applied in the role of advocacy for individuals and families (Gibson, 1993). In child welfare, advocacy can be actioned with clients who need access to services or resources to assist and teach how to overcome organizational barriers (Hegar & Hunzeker, 1988). In practice, it is implied that families are regarded as an individual in the environment and not a person with problems (Gibson, 1993). Importantly, Turner and Maschi (2014) identify that empowerment theory looks at roles of race, ethnicity and class that shapes

individual problems. The sociopolitical movement of empowerment practice with individuals, families and groups is to move away from self-blame and to focus on understanding the inequities, and to address them (Gibson, 1993).

The intervention process to apply empowerment theory includes social work skills such as communicating, listening, providing educational resources, asking questions to clarify and guide the conversation, and helping clients to participate and promote social change from a system perspective (East, 2016). To engage in empowerment theory practice combines building partnerships, exploring the situation or problem, and defining directions. The client is understood as being the expert of their situation and problem (East, 2016). Applying empowerment theory implies to work from where the client is at and to focus on meeting their day to day needs. Clients' strengths are explored and applied to help them adapt in their day to day lives. The intervention includes the provisions to instill hope for change and of their future (East, 2016).

The empowerment approach in family and group settings promote teachings and linking families to community systems or supports (East, 2016). Within this intervention, group members can learn "autonomy" and "interdependence," and practice life skills, such as "communication and problem solving" and participate in addressing "common problems" and find "collective solutions," helping others resulting in personal growth and "reduce self-blame" (East, 2016, p. 381). These groups can create a peer network to include discussions on sensitive topics which will assist in building upon skills of decision-making, problem-solving activities and techniques, develop life skills, encourage feedback, and enhance feelings of empowerment (Gibson, 1993).

Empowerment theory has been criticized for its lack of clear definition (East, 2016). There are various proposed definitions of the theory, yet no authentic application of the method

(East, 2016; Perkins & Zimmerman, 1995). The theory is criticized for its lack of measurable outcomes and has insufficient evaluation (East, 2016; Perkins & Zimmerman, 1995). The research articulates that social workers empower others; however, the power differential between social worker and client is unacknowledged (East, 2016). Wendt and Seymour (2010) suggest an inherent danger due to the lack of guidance through measurable steps in practice (East, 2016). Perkins and Zimmerman (1995) recommend a more focused application of empowerment theory, where research is defined and supports the ideals to have an intervention framework.

The weakness of empowerment theory lies at the micro-level of direct practice with individuals and families to bring awareness to the thoughts and feelings of being oppressed in society (East, 2016). Applying the theory at this level focuses on building a rapport from the viewpoint of a helping relationship. The issue is not the helping relationship but how it masks the real issues that are difficult to challenge from the perspective of social justice by marginalized populations. The theory ignores the disempowerment created by society and downplays the situation by helping clients to live or adapt to their adversities. Not all clients will take a personal stance and make it a social justice cause. For example, existing inequalities create social problems such as socioeconomic inadequacies and fail to address the impact experienced by marginalized populations as they continue to suffer the effects of lived hardships. Even though the theory is considered a social justice awareness to enhance change, there is no indicator that it will make a significant impact on the day to day lived experiences.

Leonardsen (2006) identifies that empowerment on a micro-level cannot be achieved on its own as it requires action on all three levels, including mezzo and macro (East, 2016; Hasenfeld, 1987; Mullaly, 2007). Hasenfeld (1987) supports empowerment theory to occur on three levels; person, agency, and policy. First, the worker-client relationship will build upon the

client's resources. Personal level changes may include the increase of someone's resources such as information about programming, increase knowledge, and enhance their skills to meet their desired outcomes, and assist them to change their environment (Hasenfeld, 1987). The second level of empowerment is to increase organization resources for the client. Organization resources can be fostered by social workers' knowledge and expertise to help assist in internal positive changes of organizational policies, such as including the clients' interests, influence change of policies and procedures and adopt an empowerment-based practice to help change outcomes for service users. The political level, the third level of applying empowerment theory, will help guide new policies that will make a difference in the lives of service users (Hasenfeld, 1987; Mullaly, 2007). The policy level is the participation by social workers to help organize advocacy groups, join in the collectives, for just causes, to engage in political activities to foster positive change (Hasenfeld, 1987). This may be problematic, depending on organization rules surrounding political involvement.

Anti-Oppressive Practice

Tester (2003) contends that anti-oppressive practice began in the 1970s starting with radical practice, then the ecological model, moving to the systems approach, to feminist practice, structural practice, and today, an anti-oppressive approach (Tester, 2003). Anti-oppressive practice has evolved beyond the "oppressed and the oppressor," as it includes other dimensions that need to be considered (Tester, 2003, p. 127). Anti-oppressive practice is simplified when we apply principals to include the interconnectedness of many complex factors functioning all at the same time (Burke & Harrison, 2002). One aspect is the social differences that demonstrate through power relations displayed by dominant groups affecting marginalized populations

divided by "race, class, gender, sexual preference, disability and age, religion, region, mental health and single parenthood" (Burke & Harrison, 2002, p. 131).

Further, when we consider that the personal is political (Schuster, 2017), we are referring to taking a person's connection to "family, peers, organizations and communities" and applying the individual connection to their social environment (Burke & Harrison, 2002, p. 133). When we consider the use of power in the "public and private spheres," we refer to "personal and structural levels" that are influenced by "social, cultural, economic and psychological factors" (Burke & Harrison, 2002, p. 133). These factors should be considered when assessing how individuals and groups gain the power to access resources and attain power (Burke & Harrison, 2002). Interconnectedness considers historical and geographic location where the experience gives meaning to "social facts and cultural differences" (Burke & Harrison, 2002, p. 133). The last principle to consider is "reflexivity and mutual involvement," which considers "how values, social differences and power affect the interactions between individuals" (Burke & Harrison, 2002, p. 133). These principles explain the complexities of "power, oppression and powerlessness" that people experience (Burke & Harrison, 2002, p. 133). When considering the realities of people's lives, of painful experiences, we can truly see the challenges faced, by individuals or groups, micro and mezzo, in society. The principles and consideration of its implications provide an accurate picture of how intricate oppression can occur where there are existing inequalities in society (Burke & Harrison, 2002).

Anti-oppressive practice is the act of social justice applied within the work environment and used as an internal compass to guide social work practice within institutions. Anti-oppressive practice is embraced while working with individuals and families, groups, and communities. Baines (2011) contends that AOP is the transformation of change that addresses inequalities and

awareness at the micro, mezzo, levels and to include the awareness and dismantling of the structural inequalities, macro, that prevent social justice to foster change at individual levels.

Mullaly and West (2018) suggest direct social work practice using an anti-oppressive approach includes being mindful of existing power relations of social worker-client and therefore, the perspective of anti-oppressive practice applied in a manner where 1) the client takes ownership of change which can take place on a personal level, or through cultural growth and or by social changes; 2) the social worker stimulates empowerment for the client to seek independent steps towards growth; 3) the social worker participates in critical reflexivity to help inform his or her practice, such as journaling. Reflexivity allows the social worker to work through possible learned stereotypes that could be damaging to client self-autonomy. Baines (2011) supports practice from an anti-oppressive lens to help cultivate change of Canadian's societal beliefs and norms to discontinue the colonial oppression of Indigenous populations and make changes to structures to "honour and acknowledge Native People" (Baines, 2011, p. 119).

There are challenges for implementing anti-oppressive practice theory in services where there are systemic and institutional biases. Mothers and women struggling with substance misuse are a disempowered population who have fallen victim to structural inequalities and ultimately systemically oppressed (Puurunen & Vis, 2017). This population may have complex traumas and who face shame, stigma, and criminalization (Puurunen, & Vis, 2017). In the United States, for example, it is challenging to seek help in some jurisdictions as pregnant women and mothers may be criminalized by protective services (Terplan & Minkoff, 2017). Further, this population may avoid seeking help due to an increased probability of having their child, or children taken into care and or possibly having a fear of being prosecuted through the court system (Terplan &

Minkoff, 2017). These acts of systemic persecutions make it even more challenging to break down organizational oppression.

There are challenges for implementing anti-oppressive practice theory in treatment services that may not be designed to meet the complex needs of pregnant women and mothers struggling with substance misuse. It is clear that this marginalized population need support yet many of the programs do not meet the direct needs of these families as their unique barriers keep them from seeking treatment (Puurunen, & Vis, 2017), or the program may not be designed to meet the complexities of the treatment required. In terms of treatment, this population would better be served by having access to an anti-oppressive treatment with a feminist lens to include trauma-informed substance misuse treatment (Puurunen, & Vis, 2017). Puurunen and Vis (2017) support the same treatment for Indigenous populations who may be suffering from intergenerational trauma due to colonialism. Puurunen and Vis (2017) identify that addiction workers and health professionals may not have trauma-informed training and or assessments, therefore, women may not receive the proper treatment, furthering her recovery.

There are challenges for implementing anti-oppressive practice theory in organizations. It is essential to include the efforts that are being made by the Ontario Association of Children's Aid Societies (OACAS) to address this cause. The anti-oppressive roundtable (2008), under the OACAS, contends that implementing an anti-oppressive lens in child welfare can only indeed happen when its "principles are rooted deeply within our internal structures, policies, procedures and practices" (The Child Welfare Anti-Oppression Roundtable, 2008, p. 6). An Ontario based study with 11 child welfare agencies measured caseworker interactions from an anti-oppressive approach with clients (Gladstone et al., 2014). The findings indicate that the building of the client-worker relationship is emphasized. The study supports caseworkers to have a collaborative

relationship with clients to help with the engagement process. Gladstone et al. (2014) suggest that goals are attainable when the parents feel they can participate in the solution and feel they are not seen as the problem. For implications of social work practice, it was emphasized that social workers partake in reflexivity to reduce oppression, which will have an impact on organizational structures (Gladstone et al., 2014). The practice of reflexivity may be problematic if the social worker does not engage in this practice regularly, potentially doing more harm than good.

Decolonization

Colonialism caused historical traumas and negative impacts on the culture, heritage and language of First Nations, Metis, and Inuit Peoples. Generational trauma of Indigenous families is caused by attempts to assimilate, the acts of genocide and of racist laws that attributed to psychological scaring (Baines, 2011). The trauma exposed to the Indigenous population includes the layers of pain, grief, and loss since the European colonizers (Baines, 2011). Compared to other populations, Indigenous peoples suffer from higher rates of suicide, alcoholism, poverty, addictions, and criminal activity (Baskin, 2016; Kennedy-Kish (Bell) & et al., 2017). Decolonization refers to dismantling the barriers of colonialism and the acknowledgement of the long-term effects of colonialism on the Indigenous population (Baskin, 2016). One of the changes required for decolonization is an effort by both Indigenous and non-Indigenous peoples to work together; sharing power and allyship (Baskin, 2016).

The profession of social work, the Canadian Welfare Council (CWC) and the CASW have inherent, negative, historical participatory involvement with the demise of Indigenous persons in Canada (Fortier & Hon-Sing Wong, 2018). In Canada, the profession participated in the removal of Indigenous peoples from their communities, supported the settler's state, and

acted as agents for European settlers to convince and guide families of Indigenous communities to accept the terms of assimilation (Fortier & Hon-Sing Wong, 2018). The Indian Act provided social workers authority to oversee child welfare matters on reservations (Fortier & Hon-Sing Wong, 2018). The Sixties Scoop refers to aboriginal children; more than twenty thousand children had been taken away from families and their communities (Fortier & Hon-Sing Wong, 2018). Notably, there are almost three times more Indigenous children in the care of child welfare in Canada than the number of children seen in the residential schools in the 1940s (Blackstock et al., 2004). In 2016, the Ontario Human Rights Commission (OHRC) confirmed the overrepresentation of Black and Indigenous children in care (Ontario Human Rights Commission (OHRC), 2016). The Ontario Human Rights report conclude systemic, racial, discriminatory practice within the child welfare system, resulting in recommendations to address this issue (Ontario Human Rights Commission (OHRC), 2016). Throughout the many attempts to assimilate the Indigenous peoples, there was ongoing resistance and resilience (Absolon, 2019; Fortier & Hon-Sing Wong, 2018).

Indigenous scholars are guiding the change by helping social workers and educators to decolonize. Absolon (2019) identifies that decolonization is a process to “un-learn, relearn and decolonize” (p. 16). The social work profession must participate in un-learn/relearn practices which include decolonizing the teachings from a Eurocentric lens (Absolon, 2019). Linklater (2014) contends decolonization is not just about acknowledging past wrongs; it is about putting decolonization in our social work practice and relearning what was adopted from a colonialized lens and learn to unlearn, think critically, and learn new ways of being from a new social work dimension that resembles of being an ally.

Decolonization can entail the approach of being an Indigenous helper, an ally, and learn when to "...stand beside, support, and learn from Indigenous Peoples" (Baskin, 2016, p. 389). Allies of aboriginal peoples and communities recognize the interconnectedness within the structures caused by oppression and work towards social justice cause (Baskin, 2016). Baskin (2016) discusses the helping relationship confirming that the framework includes an wholistic approach supported by the anti-oppressive practice and indigenous values seen in the Seven Sacred Teachings (To cherish knowledge is to know WISDOM, To know LOVE is to know peace, To honour all of Creation is to have RESPECT, BRAVERY is to face the foe with integrity, HONESTY is facing a situation is to be brave, HUMILITY is to know yourself as a sacred part of Creation, TRUTH is to know all of these things (p. 141). The implications for social work practice are to become an ally of Indigenous peoples and communities, and to support and participate in decolonizing social workers, educators, curriculums, educational institutions, government, policies, ultimately creating new learning tools to apply at all levels, micro, mezzo, and macro (Absolon, 2019).

Chapter 2: Description of the Advanced Practicum Environment

This chapter is an overview of the advanced practicum environment. Additionally, the chapter will provide information about the rationale for the focus of the practicum and my social location. The practicum was at the Children's Aid Society of Nipissing and Parry Sound, specifically North Bay, Ontario, covering the Nipissing District located in Northeastern Ontario. As of 2016, the population of the Nipissing District was 83,150 residents and the community of North Bay was 50,396 residents (Statistics Canada, 2019). The Nipissing District covers an area of 17,103.78 square kilometers (Ibid, 2019). Within the Nipissing District, there are three towns (Mattawa, Temagami, and West Nipissing), seven townships (Bonfield, Calvin, East Ferris, Mattawan, Papineau-Cameron, and South Algonquin), and two unorganized areas including North and South (Redbridge, Thorne, and Tilden Lake). The Nipissing District is home to two First Nation reserves, Bear Island and Nipissing (Nipissing District, 2019).

The practicum involved child protection and early intervention services such as the Infant and Child Development Program (ICDP) and the Community Action for Children Program (CAPC). The ICDP provides developmental assessments with infants and young children who may have developmental delays with cognitive and physical functioning (Early Years and Healthy Child Development Branch, 2001). CAPC provide supports to parents of the ages 13 - 22 with children from birth to 6 years of age. The Community Action for Children Program provides services to young parents who are at risk of health, economic resources or who have psychosocial needs (Boyle & Willms, 2002).

Personal Social Location

Currently, I am a white, heterosexual, middle class woman who grew up in a nuclear family, and resides in Northeastern Ontario. My social location provides a foundation of my

interactions with the world based on the social structures of my gender, class and race and awareness that power and privileged is based on these structures (Kondrat, 1999). Stating my social location is to acknowledge my privilege and how this may be a shortfall when critical reflection is not applied (Heron, 2005). Engaging in critical reflection is essential to reflect upon my internalized attitudes and assumptions as my race, and class has historically been a dominant race (Heron, 2005). Critical reflection examines the contradiction between "the world" and "my world." (Kondrat, 1999, p. 465). It is essential to recognize our social location, and understand the "self" and how it relates to others, the world and the role we play in society to "have consequences for maintaining or alter society's structures." (Kondrat, 1999, p. 471). Having a deeper awareness of self is to have conscious awareness of our internalized beliefs and to focus to transform our lives, and help alter our reality in essence to contribute to social change (Kondrat, 1999).

I was once a young, Sole Support Parent (SSP) raising twins in Northeastern Ontario who struggled with navigating inept programs. I struggled financially for many years, lived in poverty, in social housing, and in a poor geographic location in North Bay, Ontario. As a young SSP, I was judged, stigmatized, disrespected, oppressed, and faced discrimination. I succeeded in attaining education and securing full-time, permanent employment due to my persistence, personality, and mostly by having a supportive family. My career choice changed, realigned with my family needs, and met the criteria for childcare subsidy.

I work for the District of Nipissing Social Services Administration Board with the title of Ontario Works Case Manager. I have been in this sector for the last 20 years. Part of my caseload includes the Learning, Earning, and Parenting program, where young families, from the ages of

16 - 25, are supported through obtaining their Grade 12, participate in 35 hours of a parenting program, and have employment supports.

When I work with service users of the Ontario Works program, I help them identify their challenges, and work through steps to eliminate identified barriers. Through the mandate of the program, coupled with my life experiences and knowledge of community supports, I provide hope and resilience, ideally to inspire people to reach their potential, whether it is to obtain training, seek other programs, or further education. I guide service users to aspire greatness within themselves and have hope in their futures.

Within my career, I have worked in other locales to understand social problems from different realms, looking from a grassroots approach. I worked with victims of abuse in a women's shelter, and in a hospital supporting substance detoxification programs. These experiences have shown me that not all people have a support system in place, such as family and friends. These organizations allowed me to see life's challenges from a different lens and to recognize barriers, which include delays and constraints in services.

During my career, I realized that my child struggled with the misuse of substances. With my knowledge and support, I guided my child to seek help. My child suffers from mental health and addiction issues. He, in turn, experienced internalized oppression: feelings of shame, guilt, and self-hatred, common for disempowered people who face challenges. Often within my work I have heard similar stories of expressions of internalized oppression where I offer empathy for their lived experiences. The true experts to challenge social problems, such as addictions and mental health, are those who have lived experiences (Sandhu, 2017).

I consider myself a social justice social worker. My life was challenged by the neo-conservative regime that placed my family in a position of inequity which today, by feminist

scholars, is viewed as the feminization of poverty (Coulter, 2009). I experienced devastating financial hardships, burdens, and constant challenges with inept programs starting when I found myself, as a young adult and student, pregnant and unwed, choosing to be an "unwed mother." My spiral into poverty deepened with provincial cutbacks. The Ontario Conservative rhetoric of Ontario in 1995 began to initiate social policy and welfare reform (Coulter, 2009; Gavigan & Chunn, 2007; Kitchen, 1997). The most significant "government-imposed hardship" was the elimination of the Family Benefits Act (FBA), also known as "Mother's Allowance," and the download of sole support parents to the new welfare program, Ontario Works (Gavigan & Chunn, 2007; Kitchen, 1997 p. 108). Under the FBA, mothers were able to attend post-secondary education, remain eligible for monthly social assistance payments while receiving OSAP for educational costs. Under the new regime welfare recipients were no longer able to attend post-secondary studies and receive payment. Little (2001) concluded

> this has frustrated many of the single mothers interviewed. Some of them have attempted to remain in university or college courses and scrape by on the Ontario Student Assistance Program, but this requires them to carry huge debts that are much larger than the average student loan. Others have had to drop out of post-secondary education as a result of this policy change (p. 21).

The political shift of social assistance placed state responsibility on the backs of women, forcing mothers to live in increased poverty and reinforcing gender inequalities. The neo-conservative ideologies reinforced the ideals that by being a female headed family I did not have the right to mother, I was viewed as undeserving and lazy (Little, 2001).

The discourse of "practical and political activity" placed my family at the "rhetoric of victimization" (Holstein & Miller, 1990, p. 104). I had endured the shift to the Ontario Social Assistance Program (OSAP), the elimination of post-secondary school grants, and cutbacks of childcare bursaries. Further, in order to continue my studies, I had to seek childcare services

through public daycares, requiring financial help referred to as childcare subsidy. I faced needs-testing for childcare subsidy where, at that time, OSAP was calculated as income and fee for service was required. I had no choice but to follow unrealistic child subsidy guidelines to maintain childcare forcing me to work during summer months in a prescribed time frame to ensure I had childcare during the school year due to the lack of space and long wait lists.

There was no stability paying market rent housing, and I endured years on waitlists, to get into Rent Geared to Income housing (RGI). Finding and securing affordable housing is a significant concern for sole support parents (Little, 2001). When I got into Rent Geared to Income Housing (RGI), it was filthy; it was a clear indicator that I was a devalued member of society. Today, I continue to live with the financial burdens of the dismantling of the welfare state. I still have outstanding OSAP debt from twenty years ago, unpaid child support payments due to the inept Family Responsibility Office (FRO) program. I spent most of my young adulthood living in poverty doing the right thing. My poverty is gendered. Today, based on my lived experiences and constant challenges in combination with 20 years of work helping two generations of families who struggle with the same fight, I work having social purpose where I am an expert by experience (Sandhu, 2017).

I feel my role in my community is to work with families who have walked the same path as I, as a sole support parent. I have worked with individuals and families struggling with social problems such as homelessness, addiction, poverty, unemployment, disabilities, mental health, and victims of abuse. More specifically, I have worked with parents who have struggled with parenting tasks and who have struggled with child welfare. I help support parents to meet the expectations of the CAS as they work to regain custody of their child or children. I have worked with disempowered members in our community for the last two decades, helping people fight

various battles inclusive of the challenges faced with substance misuse and or who face other stressors in their lives.

I am an advocate for social justice and social change, and I am a firm believer that people ought to be given hope, guidance, and choice to have an opportunity to have a good life. Privilege is based on race, class, gender, and sexual orientation, where some people may be more oppressed than others based on these factors (Mullaly & West, 2018). My passion is to work with young families and assist in guiding them to gain knowledge and new skills to succeed. Due to my involvement with my child's struggles of mental health and addiction, and my understanding of services within the community for mental health and addiction, I am hoping to learn more about how I can help address the needs of mothers or mothers to be in our community who face substance misuse challenges.

Early Intervention Services:

Infant and Child Development Program (ICDP)

One of the programs of the Early Intervention Services is the Infant and Child Development Program (ICDP), where referrals originate from doctors, hospitals, health units, Healthy Babies Healthy Children, and other community partners. Most of the referrals are for infants who are less than 37 weeks gestation and require follow up on developmental milestones. The worker performs developmental assessments with infants and young children up to school age who may have some developmental delays with cognitive and physical functioning (Early Years and Healthy Child Development Branch, 2001). ICDP provides developmental assessments and additional referrals for physiotherapists, speech pathologists, and/or a pediatrician. The ICDP is funded by the Ministry of Children, Community and Social Services and has been in service since 1974 and operates under various organizations in Ontario, such as

hospitals, child welfare agencies, health units, and other health related centers (Early Years and Healthy Child Development Branch, 2001).

The child's development assessment tools used by ICDP in the Nipissing District are the looksee checklist's ndds (Nipissing District Developmental Screen), or the Ages & Stages Questionnaires (Squires & Bricker, 2009). Either one of the assessment tools above is applied to assess child development milestones with the infant/child and parent or caregiver (looksee checklist ndds (Nipissing District Developmental Screen), 2020; Squires & Bricker, 2009). During the assessment, the dialogue is positive and supportive. The ICDP worker provides additional reading material and a list of child activities to help enhance developmental engagement for the next follow-up. The ICDP provides services at One Kids Place, family home visits, and conducts weekly group clinics. The ICDP is voluntary and staffed with an interdisciplinary team of three; one MACP Masters in Counselling Psychology, one bilingual Early Childhood Educator (ECE), and a Registered Nurse. At the time of my Practicum, I was the only student on the team. I accompanied the workers for the developmental assessments with infants at various locations, such as One Kids Place, family home, foster care home, and at the Supervised Teaching of Effective Parenting Skills' home (STEPS).

The Children's Aid Society of Nipissing and Parry Sound offers a specialized parenting program available to multiple families with 8-week facilitation of 15 hours per week of supervised access to their children (Children's Aid Society of the District of Nipissing and Parry Sound, n.d). The Supervised Teaching of Effective Parenting Skills' home (STEPS) program administered in a home where workers provide education, support, encouragement, and assess skills for independent parenting (Children's Aid Society of the District of Nipissing and Parry Sound, n.d). In the STEPS home, families take responsibility for feeding, cleaning, bathing and

cooking for their family while supported to build healthy routines (Children's Aid Society of the District of Nipissing and Parry Sound, n.d). In the first two weeks of the program, the family's strengths are identified, goals are established, and homework may be provided to help gear the parental learning (Children's Aid Society of the District of Nipissing and Parry Sound, n.d). The program assists parents to enhance their parenting skills to parent independently.

Community Action Program for Children (CAPC)

The Early Intervention Services at CAS provide the Community Action Program for Children (CAPC) that is community-based and operational since 1993. CAPC is funded by the Public Health Agency of Canada (PHAC) under the Canadian Federal Government. The initiative of this program stems from the United Nations Summit for Children in the 1990s, where the Canadian Government announced in 1992 their Child Development Initiative, which later changed to an Early Childhood Development Agreement (Boyle & Willms, 2002). CAPC is family-focused to meet the needs of parents and their children, where parents are between the ages of 13 - 22 who have children from birth to six years of age.

The Community Action Program for Children provides services to young parents who are at risk of health, economic resources or who have psychosocial needs (Boyle & Willms, 2002). The target audience is families living in poverty, teen pregnancy, parents struggling with substance misuse and or family violence. The program includes home services to focus on the health of child and parent(s), specifically to enhance supports to meet parental needs and their goals, encourage child development, and link them to community resources and services (Boyle & Willms, 2002). The CAPC is a voluntary program that originates by referrals by community agencies in the Nipissing District and is provided by an interdisciplinary team of three; one

Ontario Certified Teacher, one Bilingual Social Worker with her Bachelor of Social Work, and a Registered Nurse. At the time of my Practicum, I was the only student on the team.

Mothercare

The CAPC program delivers the Mothercare program led by the Registered Nurse and operates weekly at the North Bay Parry Sound District Health Unit on Wednesdays from 9:00 a.m. to 11:30 a.m. Mothercare is a nutritional program focused on pregnant women and parents with newborns who face health challenges with an infant less than two months of age. Mothercare receives funds by the Canadian Prenatal Nutritional Program under the Public Health Agency of Canada (PHAC). Once the infant is over the age of eligibility, the family can obtain services from Healthy Babies, Healthy Children provided by the North Bay Parry Sound District Health Unit. The Mothercare program is joined by a Dietitian, employed by the Health Unit, who prepares nutritious breakfasts for the families. The weekly agenda includes breakfast, individual meetings with the CAPC workers, an educational component provided by the Health Unit, and cooking a meal as a group. During the one-on-one meetings with the CAPC workers, the families receive grocery store gift cards and/or local transportation cards to assist with their financial needs and to promote healthy eating. The educational session is presented by the Health Unit that comprises information that can improve the health of pregnant women, mothers, infants, families, and promotes breastfeeding.

As a student, I observed two presentations by the Health Unit; first, an overview of Canada's food guide; second, introduction to Ontario's immunization schedule for infants. Both educational presentations were informative and encouraged discussions and offered private consultation when requested. Within my practicum, the families received a no cost bag filled with fruits and vegetables purchased by CAPC from the Good Food Box. The Good Food Box in

the Nipissing District promotes affordability and healthy living by selling, at a low cost, of fruits and vegetables to families to purchase monthly, small $10.00, or large $20.00, where pickups are available throughout various locations in the district (Butti et al., 2018).

Family Enrichment Program

CAPC contributes to the Family Enrichment Program led by an Ontario Certified Teacher. The Family Enrichment Program is housed in a Board of Education building, primarily focusing on parenting programming. The Family Enrichment Program is a parenting program that provides support to parents and their children as they work toward earning up to three high school credits towards the Ontario Secondary School Diploma (OSSD). The Family Enrichment Program is sponsored by the Nipissing-Parry Sound and Nipissing-Parry Sound Catholic District School Boards and has been operational since the 1980s. The program offers transportation, childcare, breakfast, and access to a nurse practitioner and or other resources. CAPC workers attend the Family Enrichment program weekly to support their young families; Tuesdays and Fridays are designated for teen parenting. CAPC workers provide grocery store gift cards and local transportation cards to help families who express financial difficulties.

The Ontario Works program in the Nipissing District supports young families to participate in the Family Enrichment program. The Ontario Works Learning, Earning and Parenting Program (LEAP) designed for young families aged 16 - 25 who have not obtained their Ontario Secondary School Diploma. A LEAP participant can receive a bursary of $500.00 when they have completed 35 hours of a parenting program, participate in an employment component such as employment workshops or participate in a co-operative education program, and who have achieved their Ontario Secondary School Diploma. The LEAP program Ontario Works Case Manager encourages the participation in the Family Enrichment program as the

program meets the criteria for parenting hours while the family earns high school credited towards their OSSD. When families register for LEAP, it is an employment program of Ontario Works where financial support provisions are available to support such expenses as a monthly bus pass, clothing and or books and supplies.

Pregnancy Planning

In 2017 pregnancy planning became a key preventative measure for the Children's Aid Society in the Nipissing District. The Nipissing District had an influx of infants taken into care due to mothers who struggled with substance misuse. In response, the pregnancy planning position was created with an aim to support pregnant and young mothers. Much of this stemmed from the Children's Aid Society Community Forum in 2015, "Addressing Addiction Together" (Zanussi, 2015). The Children's Aid Society expressed a community concern due to an influx of infants taken into care due to substance misuse of mothers and infants with NAS. The function of pregnancy planning is provided by a family support worker who assists parents who may struggle with various challenges and who may require additional supports to prepare for motherhood. Pregnancy planning is voluntary, with referrals originating from community partners such as hospitals, doctors, and or nurse practitioner clinics.

When a referral is received, the pregnancy planner connects with the pregnant woman and begins to assist and prepare her for the birth of her child(ren). The pregnancy planner tries to contact the pregnant mother and often leaves a business card and information for her to review. At times, pregnant women withdraw or choose not to accept the community support. The reasons for this are due to stigma, fear, shame, and feeling judged (Stone, 2015). The Children's Aid Society recognizes the need for more significant supports in prevention to help guide, prepare,

plan, and assist pregnant women and new mothers. The pregnancy planner helps pregnant women by assisting in mitigating potential safety concerns before the birth of the infant.

Within my practicum, I worked with the pregnancy planner and joined her in her pursuit of connecting with pregnant women, mothers and provided support to families. Some families need more help than others, and CAS provided provisions to meet their direct needs. For example, the pregnancy planner purchased a bassinette and obtained a breast pump and supplies to meet safety concerns and to help a family in need. The pregnancy planner attends weekly home visits with pregnant women and new mothers. These "baby visits," provide an opportunity to observe diaper changes, discuss sleep and feeding patterns, assess the sleeping area of the infant, discuss safe sleep, answer questions, provide guidance, and additional resources. This type of involvement is subject to surveillance which may have adverse outcomes (Stone, 2015). Adverse outcomes may include the deterrent to seek help sooner due to fear, lack of knowledge, and the lack of appropriate supports and programming within the community. The additional resources include pamphlets such as "Safe Sleep for your Baby" and "Is Your Child Safe?" created by the Public Health Agency of Canada (PHAC). The Children's Aid Society provides a Complaint Guideline brochure to inform families of the complaint process. By the end of my practicum, I was assigned baby visits with families and completed these on my own. The pregnancy planner is a function of the Family Support Worker, having many years of work experience with CAS and in the school system with advanced knowledge and experience working with infants, children and families. This position is, at times, supported by a second colleague of the Family Support Worker team. Stone (2015) indicates that the increased NAS outcomes in infants have placed additional surveillance of pregnant mothers who struggle with substance misuse and it is considered a health concern.

Family Support

The family support workers provide various supports to families; I provided pregnancy planning and family supports. Often in my practicum, I worked with the family support worker to bring children to and from their parent-child access visits. Within my practicum, I witnessed several supervised access visits where the family support worker observed, noted the interaction, and provide support and guidance. My practicum included caring for children while the agency took the required steps to safeguard a kinship home. Kinship care is a place that is familiar to the child(ren) who may include, and or not limited to, a step-parent, a relative, friend, or a coach (OACAS, 2019).

My practicum included transporting parents out of town for supervised infant-parent visits. I assisted in one-on-one teaching of infant care primarily focusing on safety, teaching proper holding positions of infants, safety maneuvering from one position to another, guided diaper changes, and feedings while providing praise and guidance to the family. It was parenting skills and new weekly techniques introduced to build the family's self-confidence, knowledge and comfort levels.

Child Protection

In the province of Ontario, child welfare is legislated in the Child, Youth and Family Services Act 2017 (CYFSA, 2017) within the Ministry of Children, Community and Social Services (MCCSS, 2020). The Ontario child welfare system has authorized training for child protection workers, provides child protection assessments and investigations, utilizes the Ontario Child Welfare Eligibility Spectrum for conducting risk assessments during child abuse reporting, and applies new confidentiality requirements. The Ontario Child Welfare Eligibility Spectrum is

a tool used to determine the time frame required to complete an investigation for child abuse allegation cases.

On January 1, 2017, child protection workers in Ontario require specialized training to become an authorized child protection worker, which is completed in the first six months of hire. The training includes eight courses with an anti-oppressive lens and an Indigenous focus. The chapters of the curriculum include: Cornerstones of Child Welfare, Legal Framework of Child Welfare, Maltreatment and Child Development, Intake and Investigation, Professional Resiliency and Self-Care, Legal Process and Court Procedures, Ongoing Services, Part 1, and Ongoing Services, Part 2 (Ontario Association of Children's Aid Societies, 2018). Within my practicum, child protection workers had various educational backgrounds, yet mostly hold a Bachelor of Social Work degree (BSW).

The Ontario Child Welfare Eligibility Spectrum was implemented in the 1990s as a tool to identify the alleged nature of child abuse and rate its severity (Appendix A). The Children's Aid Society receives child abuse allegations by phone by the intake team. The information is logged, and with a consultation with a supervisor, when required, and assigned to an Investigation and Assessment worker, on a rotational basis. The Ontario Child Welfare Eligibility Spectrum codes assigned have legislative investigation requirement response times (Ontario Association of Children's Aid Societies, 2019). For example, timeframes to complete investigation is based on the severity rating and assigned to either 12 hours, 24 hours, 48 hours, or seven days. The main goal for the investigation and assessment team is to assess the associated risk factor(s) and mitigate the safety concerns (Ontario Association of Children's Aid Societies, 2019). The cases usually close within 45 days, with some provisions of an extension for up to 60 days (Ontario Association of Children's Aid Societies, 2019). When there are still

mitigating risks, and supported by the parents, the file is transferred to ongoing child protection services for support. There is no time frame for ongoing case files. In my practicum, I attended several investigations and assessments, which included schools in the Nipissing and Parry Sound Districts to interview children. Part of the investigation and assessment is to meet the parents and discuss the allegations.

Chapter 3: Connecting Theory to Practice

This chapter explores a guiding question for my practicum learning: can child welfare engage in attachment-focused, strength-based, empowering work with families? The primary purpose of child welfare is to ensure child safety and well-being and includes risk of harm assessments services and strategy implementation (Osmond & Darlington, 2001). This section will review areas of child welfare that attempt to include attachment concerning child protection investigations, child apprehension, child placement, and implemented programs.

Child welfare and attachment focused

Attachment is the connection between the child and caregiver during the early years of life that impacts the bond of both child and parent, affecting each other's well-being as they grow within their relationship (Levy & Orlans, 1998). Research suggests that attachment theories applied in child welfare are concerned with insecure attachments as they are prime indicators of some form of maltreatment (Osmond & Darlington, 2001). The factors that can contribute to attachment disturbances or disorders are parental and child characteristics and environmental factors (Osmond, Darlington, 2001). Parental characteristics may include depression, poor coping skills with low parenting abilities, substance misuse, abuse and neglect, intergenerational problems in parent's background, absence from caregiving responsibilities, illness, and young parenting (Osmond & Darlington, 2001). Child characteristics may include premature or difficult birth, disability, illness, lack of fit with caregivers regarding temperament, difficulty with feedings and sleeping patterns, and physical and congenital problems (Osmond & Darlington, 2001). The environmental factors that can affect attachment include socioeconomic strains, separation, abandonment, lack of social supports, inadequate daycare or no alternative care, high

levels of stress within the home, and overburdened and an under resourced child welfare system (Osmond &Darlington, 2001).

Within my practicum, child protection workers apply attachment theory when they work with families through observing the relationship and interactions of parents and their child(ren). This observation includes how parents respond to their child's cues and meet their needs. Attachment theory is widely used in child welfare to explain child behaviours due to the harm to child development precisely, the effects of fear or emotional instability (Blome et al., 2010). Child protection workers support families and the connectedness between the family members and work to strengthen the bond. Supports are further provided by recommending community resources such as counselling or other internal programs for the family. Counselling services may help assist parents in working towards a secure attachment.

Decision making regarding child protection cases depends on the Eligibility Spectrum (2019) and the Ontario Risk Assessment Model (ORAM), which are considered evidence-based tools used to measure the level of risk of necessary child protection measures (MCYS, 2016). These assessment tools do not include attachment theory in the decision-making practices for child welfare workers. In the field, discussions with child protection workers included interactions with the family and the type of supports that would best serve the family as a whole. Within the field of practice, attachment theory is acknowledged by the field staff but is not applied in investigation processes as a tool to provide additional supports to the family to build upon the family's strengths. Direct practice of attachment theory in child welfare is difficult in child welfare investigations as the primary focus is not on parent-child attachment relationship yet is to "perform immediate investigation and of provisions of services" (Bennett & Whiting, 2013, p. 270). The onus of required supports is placed on the parents to seek additional supports

for their family. Attachment-based counselling may not be readily available in Northeastern Ontario without a fee for service, which may create additional burdens on families. Child protection workers do have access to funding on a case by case basis. In essence there is a promotion of having a positive parent child attachment and there is an aim to obtain the provision of supports. The primary mandates of child welfare focuses on safety, and wellbeing of families (Bennett & Blome, 2013).

Whereas, for the cases of newborns diagnosed with NAS, the safety concerns are significant. The newborns with NAS are transferred to NICU and remain in the hospital until medically cleared. There are sparse options for the care and safety of the infant. When an infant is born with NAS, the child is taken into care under a Voluntary Service Agreement and court proceedings are initiated. There are times when the newborn is placed in the care of the other parent or another family member, referred to as kinship care. When medically cleared, mothers are discharged, in most cases, without their newborns. If newborns are taken into care by CAS, mothers can provide their breastmilk, and breastmilk is provided to the foster parent(s) or kinship for the newborn. Breastfeeding is known for its benefits for infants' care and supported by CAS. Families who are separated from their infant are provided with the resources to continue to pump their breastmilk for the infant. The focus for child welfare is to promote a secure attachment as it is fundamental in child development (Blome et al., 2010).

Research tells us that the bond between infant and mother in early life is essential for secure attachment. The apprehension of infants with NAS contributes to a disorganized attachment (Kondili & Duryea, 2019). There are high risks for separation of mother and infant when an infant has NAS, and early disorganized attachment has a significant impact on long-term social and emotional development (Kondili, & Duryea, 2019). Kondili and Duryea (2019)

recommend a holistic approach to include supporting the bond of mother and infant, with continued care after hospital discharge. Interventions of attached-informed care are provided within the hospital to include support for breastfeeding, kangaroo care, and rooming-in (Kondili & Duryea, 2019). Inclusive of discharge planning to further support these measures with ongoing assessments to include "assessment of attachment style, attachment-based interventions with mothers, and psychoeducation about NAS, attachment and parenting" (Kondili & Duryea, 2019, p. 274).

Mennen and O'Keefe (2005) support attachment theory to be used as a guide to a child's attachment in placement in child welfare practice. Mennen and O'Keefe (2005) support the use of attachment theory in practice, yet various factors can interfere with child protection. These factors include: increased caseloads, poorly trained workers, media attention, and political pressure often combined to lead to decisions that are not in children's best interests. These constraints in child welfare are not a new phenomenon. Canadian studies (Anderson & Gobeil, 2002; Blome et al., 2010; Trocme & Chamberland, 2003) refer to concerns for child welfare workers to include increase and demanding workload and caseloads, complex cases, increase time on paperwork and travel, high levels of stress, increased and unpredictable hours of work. Within my practicum, high caseloads and high workload were evident; measures were put in place to help ease the burden on child protection workers when caseloads were too high. Relief was provided to child welfare workers with high caseloads with allotted time to close appropriate cases while other staff assisted with investigations. Nevertheless, the added pressures, in turn, placed undue stress on staff.

Within my practicum, child protection workers refer families to an internal program to build secure attachment, as supported within attachment theory. The Circle of Security (COS)

programs provide additional learning tools for parents to strengthen families (Wang & Stalker, 2017) and is promoted in the child welfare domain, as an evidence-based program, for families to address issues of maltreatment, loss, and trauma (Blome et al., 2010). I attended a couple of the Circle of Security sessions with parents and found that families were receptive to the information delivered and impactful when short videos followed. The dialogue of the messages conveyed promoted a parent's ability to attend to a child's cues. The group seemed receptive to the parenting program and appeared to want to learn new techniques to apply attachment theory.

The Children's Aid Society in Nipissing and Parry Sound offers Circle of Security-Parenting (COS-P) program for service users that are eight weeks in length (Appendix B). Child welfare workers, trained in delivering Circle of Security, provide weekly designed group sessions. The educational sessions include DVD clips to help parents understand the various relationships of child development to include exploring, protection and responses by parents to help build strong bonds between them (McMahon et al., 2017). There are various models of COS interventions (Mercer, 2014). The (COS-P), a shorter, eight-week group utilizes formatted DVD sessions to reflect on parent education (McMahon et al., 2017). The CAS staff who deliver the COS program participated in a four-day intense application training (McMahon et al., 2017), whereas Mercer (2014) suggests the training is three days, costing $750 US.

There is no research (McMahon et al., 2017), or published research (Mercer, 2014), on the efficacy of the COS-P, (McMahon et al., 2017) COS-PP, and COS-HV4 (Mercer, 2014). Notably, COS treatment has not been tested with randomized or controlled groups (Blome et al., 2010). Cassidy et al. (2017) focused on COS-P that had randomized controlled trials with a low-income sample of Head Start mothers and their children where the effects of the invention had no effects on altering attachments. Cassidy et al. (2017) study shows a moderate change for

maternal attachment and no effect to child attachment and recommends further tailored approach to pretreatment for individual families. Hoffman et al. (2006) suggest that COS-P training reduces disorganization by increasing security in children toddler to early school age. Mercer (2014) suggests that the Hoffman et al. (2006) study is limited due to design and implementation and showed a moderate level of intervention. Mercer (2014) suggests that COS is not evidence-based because existing studies generally lack rigour.

Blome et al. (2010) suggest, "child welfare agencies face multiple challenges in serving vulnerable children and families" (p. 443). Research suggests that child welfare agencies are applying COS as a parenting program as a gap to assist families with attachment with their children (Blome et al., 2010; Nielsen et al., 2020). They caution in implementing a program that may not be evidence-based or effective; when the treatment does not work there may be "inappropriate blame on individual" (Blome et al., 2010, p. 431). Nielson et al. (2020) suggest that COS in child welfare organizations may be useful. The evidence supports that parenting programs in child welfare are needed in the context to help assist families with insecure and disorganized attachment and understand attachment styles is admirable, yet based on the aforementioned discussion, it may not be the answer to ensure effective treatment. Child welfare workers struggle to apply attachment-focused interventions with families. Child welfare has limitations in its attempt to include attachment theory in practice within the tools applied in child protection investigations and ongoing care and within the mandate of protection with child apprehension, child placement and in implemented programs. More work is needed to fully engage with the literature to include more attachment focused approaches in child welfare work to benefit vulnerable families.

Child welfare and strength-based approaches

There is strong support for the application of strength-based practice in the child welfare domain (Kemp et al., 2014). Strength-based in child welfare encompasses many aspects that build upon parents' competencies, develop a support system, create a collaborative relationship with clients, and support family growth (Kemp et al., 2014). A strength-based approach in child welfare reduces child risk, increases child safety while strengthening the family unit (Kemp et al., 2014). Cousins (2005) describes the approach as, "client-owned, client-directed and fundamental principles include empowerment, hope, resilience and self-determination" (p. 28). Strength-based philosophy emphasizes the notion that all families have strength and can work through challenges and build upon their skill set to meet their family's needs to include setting goals and promote family wellness (Powell et al., 1997). The approach includes relationships with family, extended family, and support groups in the community, inclusive of friends (Powell et al., 1997). The focus on problem-solving avoids blaming; instead it focuses attention on the family's ability to solve their problems based on their resources, where they are supported with strategies to build family independence (Powell et al., 1997). Child welfare strength-based approach with families begins with collaboration, sharing power with the family, and works through possible resistance to help parents engage in appropriate supports to meet their desired goals and to build a working relationship (Mirick, 2013).

When a theory is applied to practice, it provides an opportunity to understand intrinsic core applications in child protection work. In my practicum, during initial investigations of child abuse allegations, it was difficult to recognize the application of a strength-based approach of child protection workers. Even though the workers were respectful and displayed empathy, the act of the investigation alone is "intrusive" at best. It is impractical to have a helping relationship

in child welfare during the onset of a child abuse allegation investigation due to the nature of the work and the emphasis of child protection and establishing parental abilities (de Boer & Coady, 2007). Simply put, maintaining a helping relationship in child welfare is difficult (de Boer & Coady, 2007). de Boer and Coady (2007) identify that a helping relationship is based on "mutual respect, acceptance, trust, warmth, liking, understanding and collaboration" (p. 32). A helping relationship develops over time, where a relationship in child welfare is initially built upon on an imbalance of power from the first contact.

A father in Dumbrill's (2010) study of child welfare describes his perception of child protection workers, ''they've got power, scary power'' (p. 197). A mother also attested "they've got power and you either listen, or you don't listen, and you suffer the repercussions," where the imbalance of power places parents to experience fear, doubt, and judgment and impedes relationship building (p. 197). Parents are at a disadvantage during initial child abuse allegation investigations as parents do not usually understand the intervention process, are unaware of their legal rights, are guided by interventions based on what is disclosed by the worker, and may not be aware of potential outcomes, making it difficult to accept or not accept specific interventions (Dumbrill, 2010). Cousins (2005) suggests that strength-based approaches may not adequately allow for considerations of the misuse of power as child welfare workers have the authority "to define the problem, some situations tempt workers to be punitive, authoritarian and judgmental" (p. 28). Lwin et al. (2014) suggest that the perception of families is that child protection workers use power as a form of control. de Boer and Coady (2007) suggest that child welfare workers are aware of their power and how it affects a parent's ability to engage in services. Also, there is an awareness of parents' feelings to include anger, stigmatization, defensiveness, and fears of child welfare involvement due to the threat to have their children apprehended. The study supports

developing a more reliable connection between child protection and family (de Boer & Coady, 2007).

During a child protection investigation, one aspect of my role was to ensure both child safety and family home safety. One measure used to establish such assurance was to have an agreement; a set of goals created with the family to reduce the problem and or symptoms of an identified problem within the home environment (Ministry of Children and Youth Services (MCYS), 2016). A Safety Checklist ensures the home meets safety standards and includes a smoke detector, carbon monoxide detector, and securely locked firearms, if applicable. In one situation, a home was deemed to be unsafe due to a missing smoke detector, therefore, in order to keep the family together, the child protection worker purchased a smoke detector to eliminate the risk. By doing this, the worker addressed the safety concern without placing blame on the family, resolved the problem, and kept the family united. Being flexible to meet the direct needs of families is far less intrusive for marginalized families who face various challenges.

In my practicum, it was apparent that child welfare workers attempted to implement the strength-based model in their ongoing work as they engaged with families and had a positive dialogue resembling a helping relationship. They discussed having a secure support system and worked towards identifying solutions to problems, such as substance misuse. These interactions were not the initial investigations of child abuse. Kemp et al. (2014) found that parents' perception of the use of strength-based application helped with engagement in services, whereas findings also indicate a decrease of buy-in of supports when a child is taken into care. After the initial investigation, some families continued to work with the child welfare workers due to identified risks. The family was supported to enhance their abilities to strengthen their family

network, decrease the issues of the “identified problem,’ and empower families to develop and meet the identified goals. In these cases, the children remained in the family's care.

The lack of engagement of some families continues to be a concern in child welfare (Mirick, 2013). The child welfare framework has some adverse outcomes in the court system due to the lack of compliance shown by parents (Mirick, 2013). A parent's level of engagement is measured by behaviour compliance to reflect participation on the level of "attendance, attrition, retention, and treatment completion" (Mirick, 2013, p. 228). Parents' behavioural change is measured by attrition, and retention identifies if the member has completed the program, such as a treatment program (Mirick, 2013). The application of engagement and is used to determine future risk (Mirick, 2013). Mirick (2013) questions if there is a link between compliance to lasting changes on behalf of child safety.

In my practicum, I observed child protection workers focus on the family’s best interests and encourage the family to develop a support system. Workers encouraged parents to learn new techniques taught in various programs to help bring better awareness toward healing and empower them to build resilience. Ungar (2007) specifies that understanding the resilience of families who are part of the marginalized populations and requires sensitivity. Child welfare workers apply the strength-based perspective in their work with families by having the view that family members are capable of helping themselves foster positive change in their lives. Fostering independence is considered a strength-based approach with families to help identify and build upon competencies, support families as they develop newly acquired skills and provide support to access resources in the community to strengthen the family network (Powell et al., 1997).

Powell et al. (1997) identify that a strength-based approach is about creating a partnership with the family where they work as a team to share the responsibility during the support process.

In this approach, the family is viewed as the expert of their own lives and the child welfare worker is seen as a support to the family where communication is shared, and both parties have a clear understanding of their functions (Powell et al., 1997). Powell et al. (1997) suggest that this approach is difficult when the family is experiencing various challenges with social problems and may require more assistance to problem solve. It is important to recognize that the worker-client relationship is not developed on equal grounds, as child protection workers have legislative power in the relationship to make life altering decisions regarding the family. Mirick (2013) suggests that parents are not under the perception that they are in partnership with child welfare services, even when the approach is strength-based.

The therapeutic relationship of social work within the child welfare sphere is essential, yet is incredibly difficult when trying to apply strength-based principles to families involved with child welfare. There are limitations to the application of strength-based with families in child welfare at initial onset and ongoing practice. The strength-based theory works from a positive, enriching pursuit where its applications are still impacted by government policies, mandates, type of control, and removing family autonomy.

Child welfare and empowerment

Empowerment in child welfare begins with an open relationship with parents that consists of working through resistance and enhancing a focus on motivation toward change while working with child protection (Kemp et al., 2009; McCallum & Prilleltensky, 1996). Once there is no or reduced resistance, there is room to develop a non-authoritarian relationship with child welfare, which sets the parameter from working from an empowerment lens (McCallum & Prilleltensky, 1996). McCallum & Prilleltensky (1996) indicate that the next stage of empowerment is problem-solving and includes working from a non-judgmental approach.

Family empowerment in child welfare focuses on engaging families to participate in services and decision-making provisions regarding their family (Gentles-Gibbs, 2016). Taking part in family empowerment opportunities increases capability and strengthens the control of their lives while given the opportunity to gain new knowledge that can influence future lasting change (Gentles-Gibbs, 2016).

Empowerment theory is an approach that can help a family gain perspective of their family and individual values to promote personal and family growth. Within this scope, I will explore how the theory was relevant to practice within the child welfare sphere where the main goal was child safety. Gentles-Gibbs (2016) examined 30 child welfare workers and supervisors in the United States where 70% supported that the primary premise of child protection is to keep children safe. Within my practicum, there was great emphasis associated with meeting timelines and timeframes for work completed to close files at the investigation stage. Gentle-Gibbs (2016) study suggests that legislative timelines are a barrier to empowerment practice in child welfare, where high caseloads and limited time to meet the needs of families prohibit an empowerment approach to build strong allies. Gentle-Gibbs (2016) suggests that one barrier found to apply empowerment strategies was the pre-developed objectives plan that workers and supervisors apply to most cases such as "…go to parenting classes, drug and alcohol treatment, mental health treatment, find a job, [and] stabilize your housing" where the "prescribed objectives" may not apply in the same value scheme for all families, ultimately avoiding a "family's own culture, values and learning style" (p. 8). The scope of work often leaves child welfare workers feeling rushed in their daily tasks with prescribed limited time (Gentle-Gibbs, 2016). These are complaints often heard in this domain of child welfare.

Within my practicum, there was an extensive amount of consultation between child welfare staff and their supervisors. Consultation around child protection decision were required before proceeding. There were new child welfare personnel which may explain some increased levels of restrictions in decision-making practices. Notably, it may also be due to restrictive, decision-making powers of child welfare staff due to the increased legislative requirements, or possibly the type of allegation(s), and provincially set target timeframes. Empowerment theory can also be seen in the application of supervisory and child welfare staff relationships (Carley, 2004). It is essential in the work environment as the relationship between worker and supervisor can support child welfare worker empowerment within their workplace, provide mentorship, guide in decision-making, and promote professional growth (Carley, 2004).

Within my practicum, it was difficult to distinguish when a theory was applied due to the direction of the investigation, which primarily centred on the child protection and child safety. Empowerment work in child protection is challenging, because currently, child protection work is approached in a way that is contradictory to empowerment practices. McCallum and Prilletensky (1996) reiterates that the stage of investigation of child abuse is a statutory obligation where child removal from the home may be actioned regardless of parental wishes. Empowerment with families is to preserve, strengthen the members of the family and provide support to help build the capacity of decision making of child's best interest (Gentle-Gibbs, 2016). Child welfare workers work with marginalized populations who may have faced various adversities, therefore it is essential to be able to work with families at their pace to warrant them an opportunity to facilitate the required changes.

The application of empowerment theory with families in child welfare can be challenging due to the dual roles of child protectors and family growth. The two dimensions of their role may

lead to confusion and distrust of families involved with child protection. The principles of the "best interests of the child" was applied when Indigenous children were removed from the care of their family, where the policy is of western belief set which is problematic (Long & Sephton, 2011). The child safety first model is controversial due to its application in practice, specifically concerning intimate partner violence and the removal of a child from the parent who is not the abuser (Findlater & Kelly, 1999). This model requires bridging between child welfare and family autonomy while simultaneously addressing child safety to meet the needs of the family as a whole (Moles, 2008). The child welfare front-line staff are faced with many challenges, which include a range of various roles that may be restrictive in applying the empowerment tenets into practice with families.

Child welfare and anti-oppressive practice

Mullaly (2018) states that:

> (o)ppression is determined by whether a person is blocked from opportunities to self-development, is excluded from full participation in society, does not have certain rights that the dominant groups take for granted, or is assigned second-class citizenship, not because of individual talent, merit, or failure, but because of their membership in a particular group or category of people (p. 8).

When you are oppressed, it is the function of being suppressed through dimensions of race, gender, sexual orientation, age, ability, class, employment/economic status where the structures of this abuse function from an institutional framework that affects individuals by structural inequalities (Jones, 2006). AOP intentions include macro change to alter delivery of service to encompasses a transformation of an organization (Sakamoto & Pitner, 2005).

Cowie (2010) suggests that anti-oppressive practice in child welfare extends to include accountability of past participatory actions, such as the sixties scoop, recognizing the over-representation of Indigenous peoples in the child welfare system, locate privilege, become allies, engage in support of Indigenous peoples to include participating in anti-oppressive practice professional and within our personal lives. The Ontario Association of Children's Aid Societies developed an anti-oppressive framework for child welfare practice in Ontario, referred to as the Round Table, to help initiate the application of theory to practice (Wong & Yee, 2010). Yee et al. (2013) explain anti-oppressive child welfare practice includes the application of the AOP framework (Appendix C). This framework applies individual, group, and institutional dimensions. Within the framework, staff need to demonstrate that they can apply AOP skills, demonstrate that AOP is included in the team and supervisory consultations, and included in agency performance reviews (Yee et al., 2013). The AOP framework will help apply theory into practice in the child welfare domain, which can be applied as a tool to help foster organizational transformation (Yee et al., 2013). The steps of the AOP framework help apply theory into practice at individual and organization levels (Yee et al., 2013).

The application of AOP in child protection involves looking at families through the lenses of racism, sexism, ableism, poverty, inadequate housing, and other structural inequalities. Dumbrill (2012) suggests that child protection and AOP can occur at a micro level working towards having a good relationship and collaboration. Dumbrill (2012) identifies that systemic inequalities have an impact on certain groups in society that can interfere with meeting their family's needs and some groups measure better based on these structural positions. Dumbrill (2006) described child welfare as a pendulum shift moving from child safety to family-focused at the expense of ignoring the other. When child welfare is perceived as a parent's right and as

family preservation, it is emphasized as under intrusive, helping services, rule of optimism, strengths focused, and risks ignored, where there are lower numbers of children in care (Dumbrill, 2006). When child welfare is perceived as child safety it is done at the expense of the family, children's rights are emphasized, where it is over intrusion, increased policing, rule of pessimism, risks seen and strengths ignored, where there are higher numbers of children in care (Dumbrill, 2006). Dumbrill (2012) refers to the Children's Aid Society moving from a Reform era of the 1990s toward what he calls today as "transformation" within the AOP journey (p. 2). In this model, Ontario's child welfare is attempting to protect children while increasing family supports (Dumbrill, 2006).

The Children's Aid Society of Nipissing and Parry Sound integrated anti-oppressive practice through cultural sensitivities within its human resource curriculum training. An anti-oppressive module includes child welfare authorization training upon hire. The organization has developed an Indigenous Advisory and Anti-Oppressive Practice committees. Before I began my practicum, I participated in human resource training which included decolonization strategies and culturally sensitive videos on reconciliation. Some of the videos include "Call it out: Racism, Racial Discrimination and Human Rights," (Ontario Human Rights Commission (OHRC), n.d), "Cultural Mindfulness" (Couchie, n.d.), and "A Moment on the Path" (Ontario Association for Children's Aid Societies Communications, 2017, June 4). The teachings within the organization related to AOP provided the opportunity to gain knowledge, learn child welfare historical assimilation practices, and understand reconciliation within the child welfare domain. Cowie (2010) explains the process of reconciliation is to hear the truths of child welfare practices to involve those who have been affected by the system and to take accountability of the harm

imposed on the First Nations peoples and to transition to accepting Indigenous ways such as "values, culture, and knowledge" (p. 47).

Within my practicum, social workers in child welfare support families during their interactions. Families who belong to First Nations, Metis, or Inuit are further supported by their band. This means a band representative is available and present for meetings with child welfare, which ensures families have cultural supports. Families may access to services that include the talking circle and other healings ceremonies.

In Ontario, authorized child protection workers are trained to work from an anti-oppressive lens and to have cultural sensitivities. The Ontario Association of Children's Aid Societies (2018) emphasizes six critical aspects of having AOP in child welfare in Ontario: mindfulness, structural inequalities, advocacy for marginalized groups, critical thinking, working beyond an individual sphere and linking individuals to more substantial organizations, and to be able to recognize social divisions (Ontario Association of Children's Aid Society, 2018). The Ontario Association of Children's Aid Society promotes anti-oppressive practice and decolonization, which is modernized into all child protection agencies in Ontario. Authorized child protection workers received training from an anti-oppressive lens to apply cultural sensitivities to their practice and promote healing by supporting the cultural traditions of families. Supporting families include listening with a non-judgmental lens, acknowledge the challenges and encourage building upon current strengths and working towards a healing path. Child welfare workers work from an anti-oppressive lens to ensure the proper services and support are in place.

Dumbrill (2006) refers to the transformation model to increased family supports such as open adoption where families can have contact with their children, increase the use of kinship,

and include additional alternative dispute resolution measures, in all, these strategies present with reduced legal challenges and save agency costs. Dumbrill (2016) identifies gaps in this approach as it does not support inter-agency collaboration to assist family support.

Tufford and Morton (2018) examined how "Ontario social workers attempt to repair the therapeutic relationship following a report to CAS" (p. 89). Maintaining a helping relationship with service users of programs is essential, especially if there is an existing rapport with a community partner. One recommendation offered by Tufford and Morton (2018) was to enhance services provided by child protection workers to offer in-home counselling to families to avoid transportation barriers. In addition, if services cease with their current social worker due to parents' feelings of betrayal, the child protection worker could continue providing such supports through counselling. The findings of the study suggest, "…some social workers view the CAS as a valuable source of assistance for both themselves and their clients, while other social workers cite specific concerns of a systemic, collaborative, and stigmatizing nature" (p. 97). The transitional change to child welfare is intended to continue with protection and to offer support to families that are considered low risk; however, these supports appear to provide more assistance to agencies rather than families (Dumbrill, 2006).

Anti-oppressive practice with families in child welfare is possible based on the AOP framework, which guides the application of theory to practice to enhance transitional change. During my human resource training, it was encouraging to have AO principles and reconciliation learning as part of the training, which indicates some transitional progress. However, I did not observe evidence of the application of an AOP framework in their day to day cases or apply the intervention during consultations. I believe the application of AOP framework in practice has not been fully implemented or adopted by the organization. The movement towards an anti-

oppressive stance cannot be fully engaged by social workers alone, and there requires a reassurance that the organization is committed to the stance of AOP to alter a change of the structure and procedures of service delivery to enhance systemic change (Strier, 2007). It is an area where the agency can enhance their work through organizational challenges to apply the AO framework and facilitate change.

Chapter 4

Serving mothers and children: NAS and Child Welfare Practice

There is a growing body of knowledge related to mothers dealing with addiction and substance use in Canada. Ideally, health and social services will further align practices with emerging research that may challenge standard practices. Mothers with newborns suffering from NAS face psychological symptoms (Niccols, et al., 2010), mental health (Jayakody et al, 2000), and limited access to resources, supports, and information (Murphy-Oikonon et al., 2010). This review will explore the parameters of support for breastfeeding for mothers who are on opioid replacement therapy and residential models for supporting mothers using substances.

NAS and child welfare

The numbers of NAS with mothers who use opioids have increased from 46 in 2002 to 800 in 2014, a 16 fold increase in Ontario (Brogly et al., 2017). Neonatal Abstinence Inpatient Hospitalization in Ontario increased from 537 NAS infants in 2010 to 807 NAS infants in 2016 (North Bay Parry Sound District Health Unit, 2020). The North East Local Health Integration Network (NELHIN) report Neonatal Abstinence Inpatient Hospitalization numbers have increased from 57 NAS infants in 2010 to 96 NAS infants in 2016 (North Bay Parry Sound District Health Unit, 2020). Notably, there have been a total of 4996 Neonatal Abstinence Inpatient Hospitalizations in Ontario from 2010 to 2016, and 541 Neonatal Abstinence Inpatient Hospitalization in NELHIN from 2010 to 2016 (North Bay Parry Sound District Health Unit, 2020). Annually, there are approximately 30 opioid-dependent pregnant women who seek services by the Kingston General Hospital (Newman et al., 2015) Appendix D provides data from 2013 to 2018 of Cases of Opioid-related morbidity and mortality, for Ontario showing a rapid increase of Emergency Department visits since 2015, a steady increase of hospitalization,

and higher death amounts. Appendix E provides North East LHIN 2018 data of cases of opioid-related Hospitalizations by age group.

Mothers with newborns with NAS struggle with psychological symptoms of low self-worth, shame, guilt, embarrassment, and may feel like they are "bad parents." The mothers may feel rejected by family, doctors, and service providers. Mothers may struggle to care for themselves, and she may not have an appropriate support system or may not have any supports. Her fears of getting help may have begun when she was pregnant, but perhaps she did not know how to obtain nonjudgmental services or did not seek help because of fears of being stereotyped or feared to have CAS involved. Mothers with newborns suffering from NAS are more likely to have child welfare services involvement. It is likely to be a voluntary service agreement, negotiated, and involve family court. If a mother seeks help or has a newborn with NAS, child welfare becomes involved, and the child is placed in the care of the other parent, other family, or foster care.

A mother's experience of grief of the loss of her child to child protection and the challenges faced when dealing with the family court system only creates more instability and stressful events. The loss of mothering a child and having a child's presence in the home creates hopelessness, distress, pain, sadness, grief, and negative feelings that are compounded with mother blaming (Nixon et al., 2013). The women in the Nixon et al. (2013) study describe their traumatic experience of losing custody of their children, where Dawn says, "They've [CPS] taken my kids away. I don't have anybody to mother [crying] … I never smile. Everybody knows that I am not happy. You can't talk to me. I get upset and start crying all of the time. I can't deal with life—I just can't deal with it" (p. 183), and Eileen discloses "I just don't know how to hang on anymore . . . I almost tried to commit suicide. It was about eight weeks ago. I

just can't do it anymore. I'm afraid that anything I say, anything I do will get them apprehended." (p. 184). The stressful life events add to the mother's challenges and impact her wellbeing. More so, she may have to wait a long period to have visitation with her child(ren), hence why seeking help was potentially not sought initially. Notwithstanding this information, she may have lost hope, causing her to limit or halt her visits to the NICU; nonetheless, withholding herself from showing care towards her newborn, also seen as a form of self-punishment, fosters the detrimental bond of the mother-infant dyad.

In my practicum, I observed the heartbreaking truths of mothers who lost care and control of their child or children and who had limited access to their newborns at the hospital. The challenges faced are physiological symptoms affecting mothers on social, physical, and emotional levels. Therefore, the perceived experiences and effects on how fear and power are displayed can take a toll on someone's ability to cope and make changes. For example, in the situation of an infant receiving NAS treatment, the mother may feel criminalized by having the Children's Aid Society and police present, causing increased levels of fear by the mother.

In a study of child welfare services in southern Ontario, Fine and Mandell (2013) provided insight from both parents and child protection workers. What resonated with me was the possibility of viewing a situation from a "deficit/damaged lens," rather than strength-based (Fine & Mandell, 2013). The relationship between parents and child protection workers may be broken or mistrusting as the relationship is not on equal ground. Another aspect that was expressed by a participant of the study focused on Children's Aid potentially missing the component of family; forming a unity of family and Children's Aid Society. The mandate of the program may be skewed and lacks support of "family" as a unit. If the lens was changed to focus on the family, the services offered by CAS may become less intrusive for parents and reinforce a positive

relationship involvement. Fear stems from institutional involvement, naturally creating a power relationship focused on “us and them” approach.

Child welfare services focuses on the protection of children, putting greater emphasis on separating the child from family as opposed to providing additional supports to the family unit. Principally, this section focuses on how power can be construed and interpreted by parents. It reminds us to look from the lens of how we use power in the child welfare realm. The Canadian Association of Social Workers Value 3: Service to Humanity, underpins social workers’ values of their use of power within the profession to serve the needs of clients while striving for social justice (CASW, 2005). When working with marginalized groups of people, we ought to be cautious about how power is displayed and used in our profession. Some participants in the study identified that they perceived power to be “depersonalizing,” causing parents to feel prejudged and criminalized and ultimately felt they were treated poorly (Fine & Mandell, 2013). The application of power within the role of child protection should strive for a humanized approach to build a rapport with the parents to ultimately provide help, support, and have an open dialogue (Fine & Mandell, 2013).

Mothers with newborns suffering from NAS may have undiagnosed mental health and addiction challenges, and may experience grief for the loss of their newborn and or children. There is a higher occurrence of mental health with pregnant women with opioid use (Faherty et al., 2018). Coleman-Cowger (2012) suggests that it is common to have psychiatric symptoms; therefore, it promotes the intervention of mental health services with addiction services. Addiction is a chronic disorder that affects a mother’s behaviours, construed as destructive as her choices over her life may be out of control, which mimics her decisions to have negative consequences, potentially to include the loss of her child(ren) to child welfare (Velez & Jansson,

2008). Velez and Jansson (2008) identify that, "pregnant and postpartum women receiving methadone need specialized assessment and treatment for psychiatric problems, mental health counselling to include individual and group therapy, and intensive social support (to include financial, legal housing, child welfare and domestic violence services" (p. 3). The methadone maintenance therapy provide mothers with the ability to get control over one aspect of their addiction, yet more work is required to help stabilize her living environment giving her the time to work through the layers of the real causes of her addiction (Velez & Jansson, 2008).

In my practicum, I engaged with families struggling and trying to cope the best they can with very limited resources. Poverty, poor housing, histories of trauma and colonization further compounded the challenges posed by managing one's addiction and parenting. As Hoy and Cameron (2013) concluded in a qualitative study of the life stories of mothers and child welfare: "it is impossible to read these stories without confronting, the ongoing pressures of living with lesser privilege and the extraordinary efforts required to survive and overcome such obstacles" (p. 46-47).

Another challenge faced by mothers with infants with NAS is the limited access to resources, supports, and information to help guide their decisions. Velez and Jansson (2008) explain that providing non-judgmental services during and after the birth of the child prepares the mother for the physical and emotional demands of pregnancy and postpartum depression. When an infant enters NICU, the mother is discharged, thereby leaving the hospital empty-handed; without their newborn. Due to NAS, the mother may experience symptoms of being overwhelmed and discouraged to return to visit her infant at the hospital, ultimately to avoid rejection and humiliation. She may not know what her rights are as a parent, and she may not

have anyone to guide her decisions and or provide answers for her questions, or she may not know what questions to ask. Most importantly, she faces the inability to bond with her child.

Within my practicum, a mother did not know she could attend the hospital to see her infant when child protection services were involved. Murphy-Oikonon et al. (2010), in a medium-size regional hospital, explored the experiences of nurses who cared for NAS infants, their families, and the effects on the nursing staff. Within the NICU environment, infants are cared for with medications (pharmacologically), and parents find this to be stressful and difficult to understand (Murphy-Oikonon et al., 2010). The common concerns for mothers who struggle with substance misuse is the fear of being regarded as a "bad" mother, and the fear of having their child at risk of child welfare (Murphy-Oikonon et al., 2010). This leads mothers to withdraw from their infant's care and the nursing staff become the only caregivers (Murphy-Oikonon et al., 2010).

Within my practicum, volunteers were called to help provide non-pharmacological supports for a newborn. Non-pharmacological treatment is a preferred approach to alleviate NAS symptoms and helps to limit the use of pharmacological treatment. This involves a set of techniques applied with newborns such as skin-on-skin, breastfeeding, holding and being present with the newborn that is linked to maternal care. When mothers provide non-pharmacological care to their infants, it promotes mother-infant dyad bonding and attachment (Whalen et al., 2019). Whalen et al. (2019) suggest the lack of care by the newborn's mother may have an impact on the increase of physiological stress and manifest other behaviours which may be misinterpreted with NAS symptoms, such as disorganized feeding, difficulties sleeping, and increased crying. When non-pharmacological care is provided by volunteers other than the mother, it creates a disconnect with infant-mother attachment. Murphy-Oikonon et al. (2010) identified that nursing staff need additional education of addiction challenges, more sensitivity

towards mothers who have substance misuse, and awareness of the many structural and systemic challenges faced by the mothers.

Murphy-Oikonon et al. (2010) identified the lack of support for mothers who struggle with substance misuse and often, mother blaming is evident within the healthcare environment. The authors concluded that health care providers need to learn how to work with parents that meet psychosocial needs of the family. The situation illustrates the lack of information, boundaries, and clarity provided to parents to assist families. It is easy to see how families can get lost within the health and social care system. The focus of the child welfare system, with a mandate of child safety above all else may pose a risk to establishing strong connections for the infant-mother dyad, when mothers' well-being is secondary. This marginalized population requires more support than what is available and provided within health care and child welfare spheres.

Breastfeeding, substance use and child welfare

The parameters associated with breastfeeding with mothers who are on opioid replacement therapy is controversial within the literature. Shinya (2018) identifies that "…risk assessment to avoid potential drug toxicity in the infant is difficult because lactating women are excluded from drug development processes, causing lack of information on drug levels in milk when the drug is introduced into the market" (p. 151). Shinya (2018) reports that there is no data on pharmacokinetics (PK) in breast milk, which creates a risk. Pharmacokinetics is "the study of the time course of absorption, distribution, metabolism, and excretion of an administered drug (Shell, 1982, p.207)." Shinya (2018) indicate that the variation of the PK in the mother and infant may have dangers to some infants, non-exposure or exposure in the utero (intrauterine) of opioids is another area of concern causing the infant to be sensitive to opioids in breast milk (Shinya (2018, p.160). Further, Shinya (2018) recommends research clarity of PK variations of

breastfeeding mothers. Additionally, the long-term effects of exposure of the drug are unknown (Sachs & Committee on Drugs, 2013)

Opioid dependence treatment such as methadone and buprenorphine have different relative infant dose in breastmilk. In methadone, the "…relative infant dose (RID) (%) of methadone in breastfeeding is around 1% to 3% (some cases may go up to 6%) at a maternal dose of 90 mg/day of methadone" (Shinya, 2018, p. 159). This is considered safe as it is less than the cut off exposure of less than 10% for medium to high doses of methadone maintenance therapy (MMT) (Begg et al., 2002). Begg et al. (2002) specify breastfeeding is safe while on MMT as the newborns receive less than 5% of the dose, whereas, Sachs & Committee on Drugs, (2013), report less than 3%.

Buprenorphine is considered the low end of a therapeutic infant dose (Shinya, 2018, p.160). While the "…relative infant dose (RID) (%) of buprenorphine in breastfeeding is less than 1% to 2% of the maternal dose adjusted by the body weight. When compared to infant sublingual doses for opioid withdrawal (ie, 15-60 μg/[kg·day]), the infant exposure levels to buprenorphine in milk in those reports range of less than 1% to 4%" (Shinya, 2018, p. 160). Based on these figures, buprenorphine in breastmilk is the lesser of expose to newborns.

The Academy of Breastfeeding Medicine encourages breastfeeding while on methadone maintenance therapy (MMT), (Sachs & Committee on Drugs, 2013), and recommends breastfeeding when the mother is abstinent, when MMT is monitored and the mother participates in social support programs (Sachs & Committee on Drugs (2013). Pregnant women on MMT show an increase of utilizing prenatal care services, and show a reduction of fetal mortality with an increase numbers of infants being discharged to their mothers from hospitals (Pizarro, et al, 2011).

Clinical practice guidelines encourage breastfeeding for mothers, HIV negative, in an opioid treatment program, methadone or buprenorphine, where mothers are stable (Lacaze-Masmonteil & O'Flaherty, 2019). Breastfeeding is considered the favoured nutritional base for newborns, supports attachment, and helps build nurturing competency (Lacaze-Masmonteil & O'Flaherty, 2019). Breastfeeding and pumping breastmilk are supported and recognized for the benefit of the infant to include lowering the need for pharmacological treatment, and supported by the literature (NBRHC, n.d). In cases of potential apprehension, it is encouraged that bonding occurs with mother and infant, showing to lessen the effect on postpartum depression (NBRHC, n.d).

Within my practicum, I observed a close working relationship between the Children's Aid Society and the NBRHC. It is further recommended that this relationship strengthen to involve parental updates, guidance, and support child parent bonding. Within my practicum, another observation was the helpfulness of a NICU nurse who provided hands-on teachings to a mother regarding breastmilk pumping, feedings, changing, and proper cleaning of equipment.

Rooming-in is adopted by 50% of Canadian hospitals (Filteau et al., 2018). This practice is fostered in a southern Ontario hospital where the mother and infant room together providing more time for mother-infant care to enhance bonding and increase breastfeeding supports, (McQueen & Murphy-Oikonen, 2016; Lacaze-Masmonteil & O'Flaherty, 2019), with less pharmacotherapy intervention (Newman et al., 2015; Paynter, 2018; Lacaze-Masmonteil & O'Flaherty, 2019). Financially, rooming-in is known to be beneficial to health care by decreased hospital stays with little cost to implement (Newman et al., 2015; Paynter, 2018).

There are holistic approaches to the delivery of supports provided to mothers dealing with addiction and substance use in Canada. The body of knowledge presented regarding the many

challenges faced by this marginalized group focused on the psychological symptoms, undiagnosed mental health, and or having limited access to resources, supports and information. It strongly suggests that more work is needed from an interdisciplinary team approach to work with mothers with substance misuse and their infants. Breastfeeding is strongly supported for mothers on MMT for its benefits of mother and infant dyad. Other recommendations include guidelines for keeping newborns with their mothers (McQueen & Murphy-Oikonen, 2016).

Residential programming and support for mothers using substances

The placement agency was interested in understanding residential models of service delivery for this population. Specifically, my supervisors were interested in learning about shifting towards creating safe places for this marginalized population to access supports that can provide opportunities for mother to mother peer support, "mothering the mother", and to enhance and provide stability for families. As part of my placement, I researched possible models and documented residential options. The information will help guide future discussions regarding programming, including the importance of statistical measurement in community-based programs and provide guidance to meet the gap of services needed in the Nipissing District for pregnant women and mothers with substance misuse and their children.

Supportive Housing

Supportive housing provides subsidized housing to enhance health and residential stability for disadvantaged individuals (Hwang et al., 2011). Tabol et al. (2010) reviewed the literature about "supported housing" to examine this housing model and its program elements to clarify if the program elements mediated desired outcomes. The goal was to determine if modifications were needed to help measure and implement or evaluate supportive housing programs. Tabol et al. (2010) identified several terminologies to describe supportive housing,

which posed confusion for program consistency, evaluation, policymakers, and the research community. Some housing models lack program direction and confusion towards its implementation. For example, the terms “supportive housing” and “supported housing programs” are used interchangeably, wherein some articles, the meaning and characteristics need more clarification (Tabol et al., 2010).

The supported housing model is prevalent in the mental health domain as it offers independent living with supports for persons living with severe mental health challenges (Tabol, et al., 2010). The provision of services to mental health consumers changed in the 1980s, where there was a shift of consumer preference to live independently rather than living with other adults suffering from the same ailment (Tabol et al., 2010). Outreach services are considered a flexible approach and an alternative to communal residential environments (Tabol et al., 2010). The continuum of service model operates as a phased-in approach transitioning people to live independently (Tabol et al., 2010).

The mental health supported housing model has been criticized for the lack of social housing to accommodate the last phase of independent residential living (Tabol et al., 2010). There were other concerns in regards to this model such as systemic constraints of accurately evaluating the housing model, the funding was limited to meet the housing need, and the program weighed much on external agencies to provide services (Tabol et al., 2010). The supportive housing review recommended future supportive housing to include; clarity and specific mandates of the program, a standardized measurement for program outcomes, and to include regular implementation and evaluation tools (Tabol et al., 2010). Program development and validity are dependent on measurable outcomes as these can affect funding opportunities.

Types of Housing Supports

This section will explore supportive housing provided to pregnant mothers who misuse substances and their children. Krahn et al. (2018) study presents an overview of the United States housing models that include services to homeless pregnant women or women who misuse substances that provide transitional home opportunities. This review focuses on Krahn et al. (2018) study to provide areas of concern, review of housing models, and recommendations.

Krahn et al. (2018) identified a gap in research on housing models for pregnant mothers experiencing homelessness with substance misuse. There is a concern as to the effectiveness of the programs and models of housing provided in North America as there is limited efficacy for pregnant women and mothers with substance misuse and their children (Krahn et al., 2018). Similarly, there is a lack of theoretical foundation for housing interventions designed for this population (Krahn et al., 2018).

Four Housing Models

This next section will review the four housing models that are explored in Krahn et al., (2018) study: Supportive Housing for Families with Intensive Case Management (SHF with ICM), Homelessness Prevention Therapeutic Community (HP-TC), Family Critical Time Intervention (FCTI), and Ecologically Based Treatment (EBT) (Krahn et al., 2018). Some of these housing models provide case management, a continuum of care or apply a Housing First approach (Krahn et al., 2018). A Housing First approach is a philosophy that encompasses the right to have basic housing needs met, which provides a positive improvements in all areas of the family's life (Krahn et al., 2018).

The first housing model, Supportive Housing for Families with Intensive Case Management (SH with ICM) is a scattered-site permanent housing with 10 hours per month of

Intensive Case Management focused on a care plan. The care plan identifies family needs, and links them to community supports such as mental health, employment, and or vocational services (Krahn et al., 2018). The SH with ICM housing excludes women who are actively misusing substances, women who have severe mental health or intellectual disabilities, and women who are at risk of self-harm (Krahn et al., 2018). Addiction and mental health services are built into the program delivery with women who have known disorders (Krahn et al., 2018).

The second housing model, Homelessness Prevention Therapeutic Community (HP-TC), is designed to meet the need for homelessness, mental illness, misuse of substances and helps mothers and their children. It is a residential, self-help alternative program for families stemming from a 12 step model of Alcoholics Anonymous. Substance misuse is understood as a disorder, and the focus is to change the participant's views on values and lifestyle rather than the reduction of substance use (Krahn et al., 2018). This type of modification includes addressing areas of parenting, employment, community supports, and housing stability (Krahn et al., 2018).

The third housing model, Family Critical Time Intervention (FCTI), is community-based case management provided in three phases (Krahn et al., 2018). This model is scattered-site housing with no prescribed limitation criteria, such as meeting "housing ready" stipulation (Krahn et al., 2018). The first phase identifies the families' needs and helps connect the family to community supports (Krahn et al., 2018). The second phase helps the family adjust to the change of having community supports and helps the family work toward having and maintaining a home (Krahn et al., 2018). The third phase re-assesses long-term housing stability; community supports, the family's function abilities, and reviews housing changes (Krahn et al., 2018). The strengths of the FCTI housing model empower families to feel supported with increase connections to community, family, and friends (Krahn et al., 2018).

The fourth model, Ecologically Based Treatment (EBT) is a home, of their choosing, provided to mothers, where they live independently and are provided with the financial support of up to $600 monthly, for three months, to assist with shelter costs (Krahn et al., 2018). There are no contingency requirements, such as abstinence of substances or to participate in a treatment program (Krahn et al., 2018). This model includes six months or 26 sessions of in-home supports to help address immediate family needs and available on an on-call basis in times of distress (Krahn et al., 2018).

Model housing program supports for pregnant women/mothers with substance misuse is essential to improve the outcomes of this marginalized population (Krahn et al., 2018). Rapid housing availability is promising for mothers and their children, as described in housing model three (Family Critical Time Intervention) and four (Ecologically Based Treatment). The Ecologically Based Treatment has been identified as a national housing model to end homelessness in the United States (Krahn et al., 2018). The idea of meeting a "housing ready" criterion for this population is not supported as these families would strongly benefit from being housed (Krahn et al., 2018). Whereas the first housing model reviewed, Supportive Housing for Families with Intensive Case Management, does not adopt a housing first model and its primary focus is on community support to alleviate obstacles that affect housing security. A positive outcome to reduce stress for families is to have options of being housed (Krahn et al., 2018).

Housing models that include case management have a critical role to build a positive relationship and support families and collaborate and link them to community partners (Krahn et al., 2018). Krahn et al. (2018) recommends additional long-term case management to assist in housing maintenance, maternal care and work through other barriers faced by pregnant women and mothers with substance misuse and their children. The outcomes of case management

housing models, FCTI and EBT, found that children had better mental health which suggests that this approach facilitates positive changes (Krahn et al., 2018). Additional research is recommended for improvements of case management within the housing models (Krahn et al., 2018).

Krahn et al. (2018) study acknowledged the provisions of support to promote stability for pregnant women or mothers. The supports include access to childcare and housing subsidies. These provisions have positive impact on the mother's ability to work outside the home and or attend treatment for substance abuse and or attend mental health counselling (Krahn et al., 2018). Transportation provisions and food vouchers was identified as a positive benefit (Krahn et al., 2018). The study emphasized maintaining a positive connection of community groups to mothers (Krahn et al., 2018). Most importantly, Krahn et al. (2018) recommends a trauma informed approach with pregnant women or mothers (Krahn et al., 2018).

An Ontario Housing Model

The Jean Tweed Centre (JTC) is a Toronto Ontario-based housing model that provides services for pregnant women and parenting women with concurrent mental health and substance misuse. JTC is a women-centred housing model guided by an anti-oppressive approach with trauma-informed practice and promotes "…increased housing stability, improved family life and an increased sense of safety and well-being" (Shah et al., 2017, p. 283). The JTC is a residential model demonstrated cost saving to the health care system showing lower Emergency Department visits and fewer needs for Withdrawal Management Services (WMS). The JTC addiction treatment program has helped participatory families to gain custody of their children who were apprehended (Shah et al., 2017).

Shah et al. (2017) identified two models of supportive housing services at JTC; residential home and inner access program offering supports to a specific area or building, also referred to as cluster care. The residential home model is considered a communal living environment with a waitlist of up to three months. The supports include day programming, continued care, and outreach services. JTC includes the provision of criminal justice system liaison and guidance for women (Shah et al., 2017). Shah et al. (2017) recommend further long-term research for inner access and programming.

The American models presented by Krahn et al. (2018) provide direct provisions for this population to meet their needs. Some models have more benefits than others with various styles of supports. Housing supports that include Case Management were favoured as they provide more one-on-one contact with families yet display a lack of depth to the service provided and may have limitations as a therapeutic approach to address the trauma of this population. Whereas the Canadian model of JTC programming provides an in-depth healing model of care that addresses women's past-traumas and substance misuse. There is a connection between addiction and past sexual and past physical abuse (Harris & Fallot, 2001). Trauma-informed addiction programming is a model that addresses the whole person with individual support to work through childhood trauma and understanding of the use of substances (Harris & Fallot, 2001). Part of the trauma and substance misuse approach is to include other services such as safe housing, legal services and health care, where housing is a top precedence. Applying a women's approach to healing addressed a women's path to work toward healing of self in healthy ways (Harris & Fallot, 2001). The Canadian model has more to offer pregnant women and mothers who struggle from substance misuse.

Bringing Awareness to Existing Gaps

The review of Residential Programming and Supports provides various options and styles. The following information will bring awareness to the existing measures that are crucial to create opportunities that can help facilitate change. There is a contentious historical issue in Canada of access to affordable housing (Shah et al., 2017). Shah et al. (2017) defines under-housed as "… anyone without access to safe, secure and affordable housing" (p. 282). Bassuk and Geller (2006) indicate there are risks to family homelessness to ".. include minority status, childhood sexual abuse, foster care placement during childhood, recent eviction, frequent moves, recent pregnancy or birth, and recent hospitalization for mental health or substance abuse problem" (p. 782). In Canada, homelessness is considered gendered due to the majority of homelessness faced by female-headed families (Vandenbeld Giles, 2014). Pregnant women or parenting mothers are a marginalized population exposed to poverty, inclusive of our youth, and challenged by mental health, substance abuse and potentially child protection issues (Shah et al., 2017). Shah et al. (2017) report that more than 300 infants are born to mothers living in Toronto who are under-housed. Pregnant women who find themselves homeless are usually young (adolescent) and are affected by multiple stressors (David et al., 2012). Homelessness may be considered a form of child neglect (Robertson, 1991). Pregnant women who struggle with substance misuse lack in accessing help from health care due to stigma, shame, and fears of child apprehension by child welfare (Rutman et al., 2000). Child protection matters are prevalent in the literature when speaking of pregnant women and mothers who struggle with drug misuse, where child apprehension causes significant distress in mothers resulting in grief and loss mitigating the support of residential programs (Ministry of Health and Long Term Care, n.d.). Mother-child separation has long term adverse effects for mother and child, such as affecting a

child's psychosocial functioning, cognitive development and social competence, whereas this separation exacerbates other areas of the mothers' life (David et al., 2012).

Recommendations

The research recommends immediate addiction treatment services, specially designed for pregnant and new mothers, and to have set protocols between child welfare and substance programs for pregnant women in Canada (Canada FASD Research Network's Action Team on Prevention from A Women's Health Determinants Perspective, 2014). Policies include the relationship between child welfare and substance programs to include guidelines to support parents while pursuing addiction treatment or supports that do not put the parent at risk of having their child taken into care (Ministry of Health and Long Term Care, n.d.). There are limited programs for pregnant women and mothers due to restricted mandates of programs and or women having to choose between their families and treatment (Gendering the National Framework, 2010). Some mothers and pregnant women are rejected for services due to the complexities of their situation, which may include past trauma, dual diagnosis (mental health and addiction), health, and housing restrictions (Gendering the National Framework, 2010). It is encouraged to have programming to be women-centred rather than from the lens of a child or fetus approach (Gendering the National Framework, 2010). It is recommended that support be accessible in the community, close to home, and provides regular care (Ministry of Health and Long Term Care, n.d.). Mainly, treatment is to meet the direct needs of pregnant women and mothers where the services are flexible, accessible and reflect the lives of women providing a safe environment for families to receive care (Ministry of Health and Long Term Care, n.d.).

In summation, the residential programming and supports provide details of some shared concerns and strengths. Within the context of Canada, it was essential to touch on some points

relating to the housing crisis and some leading child protection concerns to understand true interconnectedness. Various lessons have identified concerns about program services and their lack of measurements. It is in hopes that this review will provide additional insight into residential programming and supports for pregnant women and women who struggle with substance misuse and their children that require proper development, measurable outcomes, and that meet the direct needs of the families in the Nipissing District.

Chapter 5: Critical Reflection of Advanced Practicum

This chapter will provide a critical reflection to include self-care and identify organizational strengths, gaps, and future opportunities. In conclusion, I will refer to the implications of social work practice, and I will provide feedback on my experience and my future study and hopeful opportunities.

Reflection

Social workers use various techniques to inform their practice to include theory, research, and self-reflexivity. Social work practice influenced by critical reflection provides an opportunity to learn, understand, and build new knowledge. Self-reflexivity is a guide that helps reveal certain aspects of your work to reflect on your social location and build upon knowledge to help understand the relationships to foster and influence change. Being reflexive is a foundation approach to view our practice from an anti-oppressive lens, allowing room for self-awareness, growth, and to build new knowledge to encourage continuous learning. Within my practicum, one of my learning goals includes self-reflexivity and self-care as a tool to learn how to alleviate oppression faced by parents involved with the Children's Aid Society and how to empower parents.

In this section, I will review how to change the paradigm of judgment when we work with parents involved with the Children's Aid Society. The discussion to follow will include tools to make mindful decisions in child welfare. I will discuss our language, social problems, and the importance of reflection to help identify our contribution to oppression within society and within our workplace.

How we use language is essential for social workers. Oppressive factors may exist in how we describe family situations where they may have harmful elements and associated with

stigmas creating a further divide. For example, the term "addict" can be interpreted negatively, is stigmatic when applied to individuals' lives, and we should be cautious about how we attribute to their destruction (Mullaly & West, 2018). Instead, the term used should reflect the person to have "struggles" with substance dependency and instead lives with a health-related issue (Mullaly & West, 2018). Mullaly and West (2018) contend that, "unless we critically reflect on statements we make about individuals, we run the risk, at minimum, of perpetuating an oppressive label and, at worst, of them becoming criminalized, losing their housing, or having their children apprehended" (p. 301). In reflection, within my writing, I learned the appropriate terminology and the importance of its implication and effects on disempowering a group of marginalized populations.

Second, within my practicum, I felt uncomfortable entering homes of families that were unclean, smelled, and had either an abundance of belongings or barely anything. I found it challenging to apply a non-judgmental lens. I was comparing my lifestyle to others, and this made me feel guilty and sad for my privilege and the defeat of others. Within the social welfare system, most contact made is in an office, and the realities of poverty are often unseen and misunderstood (Mullaly, 2007). Further, you lose the sense of the families' actual reality. In child welfare, you enter homes of families, and you witness authentic lived experiences with a more profound context. In exploring these feelings, it has brought me awareness. Within my journey in my placement, it is evident that social problems have become individual family problems (Mullaly & West, 2018). The reality of the lives of low-income families and its obscure stereotypes of blaming the victim are negative connotations brought about by structural inequalities that prevent people from attaining more wealth in society. When we view social problems with a subculture lens, it implied that the subculture groups of race, ethnicity,

sexuality, and class have inherent values placed on them and attributes to the culture of poverty (Mullaly & West, 2018). Being defined by society and living in the effects of social problems, more so than the privileged, you tend to internalize feelings of subservience having a significant impact on the role of the cycle of poverty (Mullaly & West, 2018). Mullaly and West (2018) support reflexivity as it allows social workers to regroup and view the family's realities rather than the alternative of the lens of stereotyping and pre-judgement. In reflection, within my practicum, it is valuable to understand privilege and to understand social problems from the context of individual, family, and subculture levels (Mullaly & West, 2018).

Reflection helps identify our contribution to oppression. Another way to alleviate oppression faced by parents involved with the Children's Aid Society and how to empower parents is to listen, listen to their stories and validate the challenges they have overcome within their limitations. Show compassion and empathy and move away from blaming the victims of social problems. In child protection practice, it is difficult to look at family life situations without reflecting on your own family experiences and standards of living. One aspect that I found challenging was not to impose my values upon other individuals and families. Instead, I refocused on the family's identified needs and work with the family to provide solutions to problems and work together to bridge any existing gaps.

Within my practicum, my reflexivity included areas that I encountered that led me to feel uncomfortable and questioned my appropriate thinking as a student in child welfare. In theory, we talk about oppression, and in reality, when we work with fewer privileged families who live in poverty, we must be cautioned not to contribute to being the oppressor. Being reflexive allows the opportunity to challenge stereotypes, and perhaps some negativity that encompasses social problems. Families with less have less, therefore, be cautious of judgement. When we apply a

non-judgmental lens, we are working from understanding our privilege. In order to change the paradigm in judgment in social work practice, specifically in child protection, it is essential to learn reflexivity and become a critical thinker. It is essential to begin by making use of applying sensitive language, know the intricate layers of social problems experienced by individuals, families and subculture levels, and work with families from an anti-oppressive lens with cultural sensitivity.

Self-Care

Self-care is different for everyone and can be practiced in various ways. For this review, self-care reflects upon organization commitment, recommendations for social work education and our journeys. One of my learning goals in my practicum was to include self-care as a tool when working to alleviate oppression faced by parents involved with the Children's Aid Society and how to empower parents. Social work involves working with vulnerable populations; therefore, social workers must be diligent in providing sufficient services. Self-care can be achieved, in its fullness, by having supportive workplaces, a commitment of social work student curriculum to include self-care practice, and to promote individual care for health and wellbeing.

This section reviews workplaces that employ social workers and reflect upon the significance of self-care adopted by organizations. There are many challenges to social welfare environments; one foundation of the work is following a specific mandate for marginalized populations. Social welfare services can be defined as the provisions of supports to individuals and families who struggle with a broad range of social issues such as unemployment, addictions, mental health, disabilities, homelessness, immigration, and victims of abuse. Social workers work with child abuse survivors, families working through domestic violence, victims of crime, and other catastrophe events (Bride, 2007). The effects of stress experienced by social workers

may be intensified due to the effects of work conditions describe as working in a constant crisis mode, with unreasonable demands, having elevated caseloads (Profitt, 2011), with high needs of service users, and with limited resources (Kennedy-Kish (Bell) et al., 2017; Profitt, 2011). These types of high service demands Collins (2020) emphasize the attention of self-care to be of an organization's obligation for staff rather than of individual silos. It is essential to recognize the type of work we do so that we can measure best how to work with staff to encourage the commitment to staff.

Notably, front-line social workers may leave their employment early due to stressors experienced in the environment and or they have reached the "burnout" level (Bride, 2007). Social workers can experience secondary traumatic stress (STS) if exposed to repetitive stories of experienced trauma. Within my practicum, I was pleased to see that the Ontario Association of Children's Aid Society fulfill their training to include a chapter on Professional Resiliency and Self-Care for authorized child protection workers. In reflection, this is a stance to a commitment from the organization to its staff to be mindful of self-care practices and the impacts of the work environment. Collins (2020) presented that child welfare workers and social work students who apply self-care in their lives result in having an increase in compassion gratification. Self-care practices of child welfare workers and social work students include participation in exercise, spend time with friends and family, participate in hobbies, and use humour in the workplace (Collins, 2020). In my practicum, I discussed self-care practices with Children's Aid Society staff and based on the conversations, much of the staff include a personal commitment to physical activities, others attend group activities such as painting nights, and emphasized their commitment to having work life balance. Having other passions outside of work contributes to being the best version of ourselves.

There are many reasons why people are attracted to the profession of social work, whether it is to help others who have had experienced similar adversities or to help re-align social justice practices. The primary goal for social work students is to reduce stress by focusing on five parts of self-care plans to include mental and emotional, physical, social, spiritual, and self-care (Moore et al., 2011). Most importantly, researchers Moore et al. (2011) recommend self-care techniques such as journal writing in graduate-level courses as it is a tool to assist students in implementing techniques to support "emotional, physical, mental, social, and spiritual well-being" (p. 7). Mastering self-care techniques by social work students should be encouraged as this profession plays a significant role in working with marginalized populations.

As a student at Laurentian University in the BSW and the MSW programs, one of the most fulfilling experiences, was to participate in the course, Introduction to Indigenous Social Work, SWRK 5096, taught by Professor Marcia Manitowabi. This course was a place of healing for a small group of students, fostered change, and learning fundamentals for self-care, which included shared stories, our journeys, and the learning of Indigenous ways of knowing. In this class, I learned many new approaches and gained new knowledge through storytelling by my professor and the Elders. One thing that resonates within me is, "..am I doing this in a good way?" (Manitowabi, 2019). I have applied the Medicine Wheel teachings of the different aspects to help with self-focus toward the direction of balance and harmony, which has given me sound insight. I believe that self-care is being kind to self and to work through challenges. Self-care can be improved in social work student curriculums to include courses that provide a deep lens into oneself and fosters strength, empowerment, and encompasses anti-oppressive practice with cultural teachings and self-awareness.

Another vital component is viewing oneself and how we foster individual self-care practices is to live a good life. Individual self-care from an Indigenous perspective is to have balance and to be still in our paths and learn along the way about ourselves, others, and to apply the teachings we have learned. The Anishinabek Medicine Wheel, spirit, physical, emotional, and mind focus on self from four aspects where we seek balance, equally, from the four spheres (Linklater, 2014). You cannot heal if you are not focusing on the four quadrants (Linklater, 2014). We must be kind to ourselves and learn new ways to grow professionally and to grow on a personal level. Baskin (2016) urges the necessity to work towards wellness and balance. These are "wholistic" teachings that guide us in our daily walk in life. "…Aboriginal women's understanding of wellness coincided with self-care. A common expression in Indigenous communities is "walk the talk," often implies that those in a helping profession must exert considerable effort to advance along their healing journeys" (Linklater, 2014, p. 77). Baskin (2016) emphasis that social workers are to participate in self-reflexivity and self-care, as it is essential for personal healing. Reflexivity has helped me grow professionally and personally. It is essential to recognize the hard work and the importance of the work we do as social work practitioners.

Social workers have an essential role in society and self-care should be encouraged in institutions that employ social workers and be practiced early in social work education curriculums to help master the techniques for individual care. Social workers can address the needs of service users when supported at the onset. The self-care regimes promote wellness and grasped when all multitudes of efforts are seen and applied by employers, teaching institutions and individuals. With these efforts, practitioners will be encouraged to apply the self-care techniques regularly so that they can meet the demands of the work and meet the needs of

service users. Social workers provide support to parents involved with the Children's Aid Society by being sensitive, compassionate, and empowering. The Indigenous ways of being are self-care for self, family, and the community.

Strengths

Within my practicum, I found that the Children's Aid Society of Nipissing and Parry Sound had much strength within our community. In this section, I will identify a trend in the use of information and creating programs beyond legislative requirements and financial support to meet the direct needs of families. As previously mentioned, I shadowed the Early Intervention Services teams and the child protection team.

A significant trend seen in the organization was the use of its resources to help service users. All departments made use of the resources that were applied interchangeably amongst the programs. For example, the child development assessment tool Looksee Checklist's ndds (Nipissing District Developmental Screen) used in more than one department. The assessment tool focuses on child development, which creates a connection between parents, child(ren), worker and helps build rapport. Second, the organization's strength was the initiation and the implement of two programs, beyond legislative requirements, to meet the direct needs of families. These programs are the STEPS and Circle of Security. They help build positive connections for families that stem from attachment theory and are strength-based. This type of commitment by the organization is powerful as it is to assist in fostering change within families and hence make a difference in our communities. Third, the organization showed strength as financial provisions were accessible in all departments. As previously mentioned, the programs have access to financial support to bridge families with food vouchers, transportation passes, and

furnishings/supplies required to keep the family together. The organization is committed to the families it serves within our community.

Within my practicum, I was able to recognize significant strengths that resonated in all the departments. The strengths are of sharing resources and information that was utilize in all program delivery, program development and is based on family needs, and financial resources. The practicum in the Early Intervention teams and the child protection team provided me with an understanding of how families are best served in the community by this organization.

Gaps

One of my learning goals was to learn more about the policies and laws that affect caregivers involved with the Children's Aid Society. This section will review child welfare issues and the gaps in services that may affect the helping relationship with parents. The following section will include observations around data collection, organization limitations, and outside agency restrictions.

One area that would be essential is to have access to statistical evidence of child abuse allegations gathered from the Ontario Child Welfare Eligibility Spectrum. Concerns of substance misuse by the parent is not separate in a category; therefore, an actual number of child protection and substance misuse by the parent cannot be calculated. More specifically, the cost of the services provided to this marginalized population cannot be calculated. It would be beneficial to apply a measure of costs to the Ontario Child Welfare Eligibility Spectrum to collect data to identify strengths and weaknesses based on geographic locations in Ontario and accurately measure the needs of child protection cases in Northeastern Ontario. Child welfare agencies in Ontario use the Curam Software where data could be collected based on the Eligibility Spectrum level of risks and scale. The data could be collected and analysed to determine the greatest needs

of families based on district to help identify programming needs of those communities. The more information we gather, the better to identify community needs where programming and access to funding could be implemented to meet the direct needs of families. For example, if a community identifies child protection matters of mothers who struggle with drug misuse and have infants with NAS, then a program could be designed to provide treatment, be community-centred, and link to community supports.

Within my practicum, children entered foster care in another district as foster care services could not meet the needs in the geographical location of the family. Foster care is an approved service for children from birth to eighteen years of age, where foster families are trained and approved by the Children's Aid Society (OACAS, 2019). For this review, foster care homes are utilized for child placement, where kinship services (family members) are not available (OACAS, 2019). Foster care is available for families as support to parents, families, and or child protection cases (OACAS, 2019). I observed a lack of foster homes in the community where families reside. While a child is in foster care, families are provided with approximately three visits per week, which is a limitation. It is common in the North to have several parent-child cancelled visitations due to weather conditions. I believe this is very difficult for the parents and the children involved who may struggle with the separation. When we do not have efficient provision for families, they are bombarded with the time-consuming task to access parent-child visitations and the lack of volunteer drivers to meet the needs of families. This is not a new dilemma of the limited resources in northern communities.

Outside the organization, there seems to be a lack of support for pregnant women and mothers who struggle with opioid or other drug misuses. Counselling for pregnant women and mothers is available for opioid addictions at the Community Counselling Centre of Nipissing.

The absence of an appropriate treatment program in the north creates significant gaps for pregnant women and or their children. Pregnant women and mothers who struggle with opioids or other drug misuse do not have access to specialized treatment programs in the north and require more supports to meet their needs.

Another limitation, outside the organization, is the lack of support provided by hospitals to mothers and infants who struggle with opioid or another drug misuse. For example, when infants are admitted to NICU, the mother is discharged, affecting the bonding of the mother-infant dyad. When the infant is discharged to the child protection agency and brought to foster care, the mother has limited access to bond with her infant. More discussions should take place to create a stronger mother-infant dyad to simulate a rooming-in facility as implemented at Kingston General Hospital. In child protection matters, the secure attachment of mother-infant is encouraged and could be encompassed when a mother and infant is discharged to specialised treatment home to support the family by offering anti-oppressive, trauma informed programming and care to include breastfeeding, skin-on-skin, and parenting supports.

Opportunities

I was able to contribute to the Early Intervention Teams at the Children's Aid Society by sharing information. I presented material on the Ontario Works legislation to include information regarding the Learning, Earning and Parenting program. We must take the opportunity to build strong alliances in our community, other municipalities, and share knowledge, resources, and implement affirmative programs. Further, taking an opportunity to work in partnership will help meet existing gaps that will strengthen individuals, families and our communities.

Implications for Social Work Practice

There are substantial implications for social work practice with mothers and women who struggle with the misuse of substances and their children. There is a need to work in a multi-disciplinary team to include hospitals, social services, child welfare, addiction treatment programs, and counselling agencies. There are gaps in services provided to pregnant women and mothers with substance misuse. There is always room to grow, learn, and work together to meet the direct needs of this marginalized population. Northern communities need programs that provide quick services for addiction treatment, mental health, and housing. My recommendations include planning and developing a residence for pregnant women and mothers who struggle with substance misuse and their children. This home should foster mother-infant dyads to support breastfeeding, skin-on-skin, and substance misuse treatment, mental health that can create stability for the family.

Experience and Future Study and Opportunities

My experience at the Children's Aid Society at Nipissing and Parry Sound in North Bay, Ontario, provided me with the opportunity to apply theory to practice. In combination with my work experience in social services, child welfare practices gave insight into legislative requirements and challenges faced by mothers with infants with neonatal abstinence syndrome. Hopefully, this paper will lead to further discussions about research and programming to meet the needs of young women and their children in our district. I am eager to have the opportunity to work in various areas of research to assist in developing and planning community initiates towards this foundation in the Nipissing District.

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Appendices

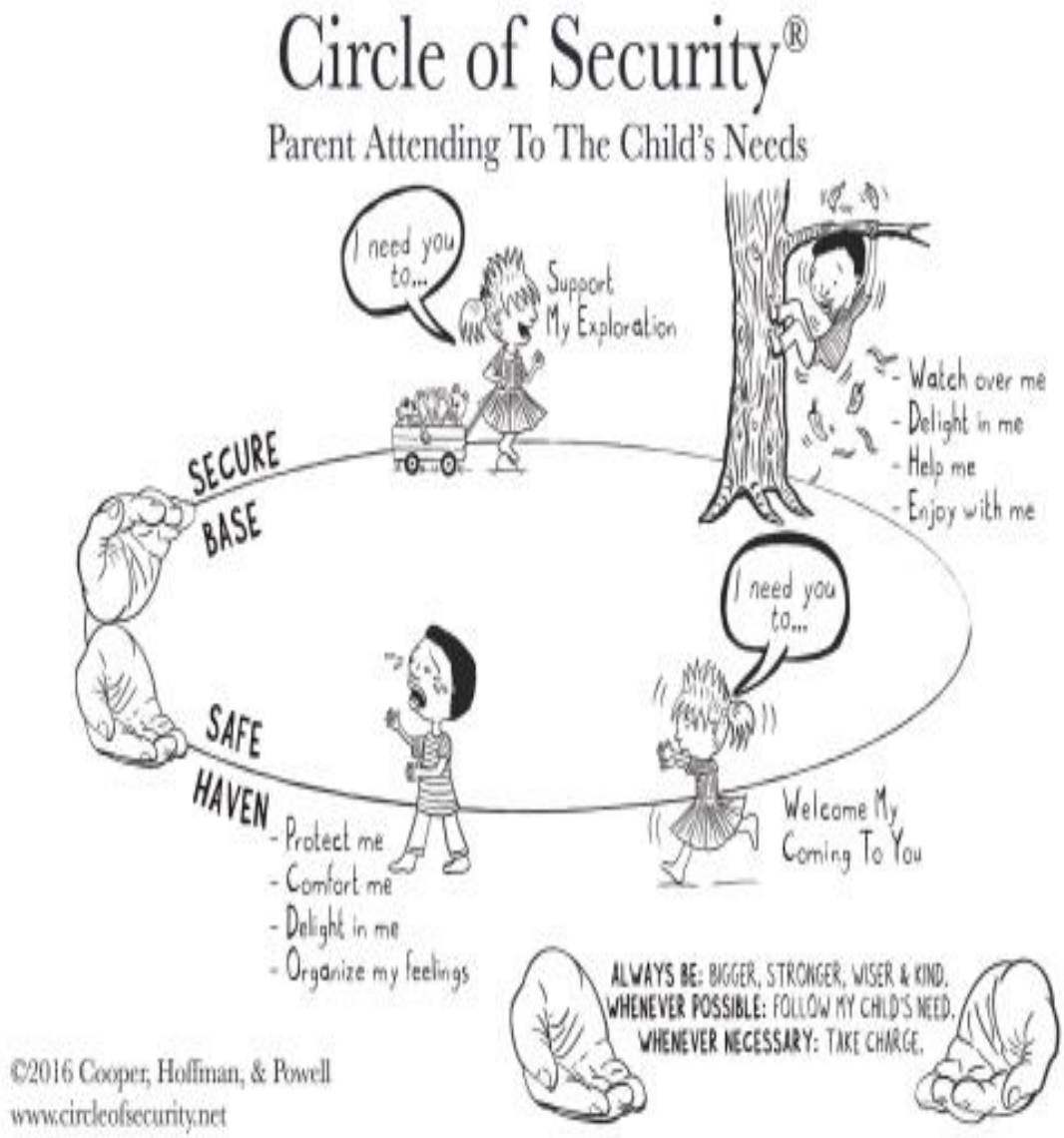
Appendix A – Ontario Child Welfare Spectrum Eligibility

		Level of Severity			
SECTION	**SCALE**	**Extremely**	**Moderately**	**Minimally**	**Not Severe**
SECTION 1 Physical/ Sexual Harm by Commission	1. Physical Force and/or Maltreatment	**A, B, C, D, E**	**F, G, H, I, J**	K, L	M
	2. Cruel/Inappropriate Treatment	**A**	**B**	C	D
	3. Abusive Sexual Activity	**A, B, C, D, E,F**	**G, H, I, J**	K, L	M
	4. Threat of Harm	**A**	**B, C**	D	E
	5. Child Fatality	**A, B, C, D, E, F**	**G, H, I, J, K, L**	M, N	O, P
SECTION 2 Harm by Omission	1. Inadequate Supervision	**A**	**B**	C	D
	2. Neglect of Child's Basic Physical Needs	**A**	**B**	C	D
	3. Caregiver Response to Child's Physical Health	**A, B**	**C**	D	E
	4. Caregiver Response to Child's Mental, Emotional, and Development Condition	**A**	**B**	C	D
	5. Caregiver Response to Child Under 12 Who Has Committed a Serious Act	**A**	**B**	C	D
SECTION 3 Emotional Harm	1. Caregiver Causes and/or Caregiver Response to Child's Emotional Harm or Risk of Emotional Harm	**A**	**B, C**	D	E
	2. Child Exposure to Adult Conflict	**A, B, C, D**	**E, F, G**	H	I
	3. Child Exposure to Partner Violence	**A, B, C, D, E**	**F, G, H**	I	J
SECTION 4 Separation from Parent/ Caregiver	1. Orphaned Child or Parent/Caregiver Unavailable	**A, B, C**	**D**	E, F	G
	2. Caregiver-Child Conflict/Child Behaviour	**A, B**	**C, D**	E	F
SECTION 5 Caregiver Capacity	1. Caregiver Has History of Abusing/Neglecting/Exploiting	**A, B, C, D, E, F**	**G, H**	I, J	K
	2. Caregiver Inability to Protect	**A, B**	**C**	D	E
	3. Caregiver with Problem	**A**	**B**	C	D
	4. Caregiving Skills	**A**	**B**	C	D

Section	Scale	Unranked Choices
SECTION 6 Request for Counselling		A, B, C, D, E, F, G
SECTION 7 Request for Adoption Services	1. Adoption Services for Potential Adoptive Families	Scale 1: A, B, C, D, E, F, G
	2. Adoption Disclosure	Scale 2: A, B, C
	3. Services for Birth Parent(s) Considering Placing Child for Adoption	Scale 3: A, B, C
	4. Adoption Probation Services	Scale 4: A, B, C
	5. Post Adoption Services	Scale 5: A, B, C, D, E, F, G, H
SECTION 8 Family Based Care	1. Foster Care Services	Scale 1: A, B, C, D, E
	2. Kinship Service for Child Who Has Been or Will Be Living with Kinship Service Provider(s)	Scale 2: A, B, C, D, E, F, G, H, I
	3. Kinship Service for Children and/or Youth in the Care of a Society	Scale 3: A, B, C, D, E, F, G, H, I, J
	4. Customary Care	Scale 4: A, B, C, D, E, F, G, H
	5. Custodial Parents – Application, Approval, Placement	Scale 5: A, B, C, D, E, F
	6. Custodial Parents – Post Placement Services	Scale 6: A, B, C, D, E, F, G
	7. Licensed Services to Residential Care (OPI/OPR)	Scale 7: A, B
SECTION 9 Volunteer Services		A, B, C, D
SECTION 10 Request for Assistance		A, B, C, D, E, F, G, H, I, J, K
SECTION 11 Request for Youth Services		A, B, C
SECTION 12 Personal Information	1. Record Check	Scale 1: A, B, C
	2. Individual Rights to Access and Correction	Scale 2: A, B
	3. Use and Disclosure	Scale 3: A, B, C, D, E, F, G
	4. Breaches	Scale 4: A, B, C, D, E, F
	5. Complaints	Scale 5: A, B, C, D

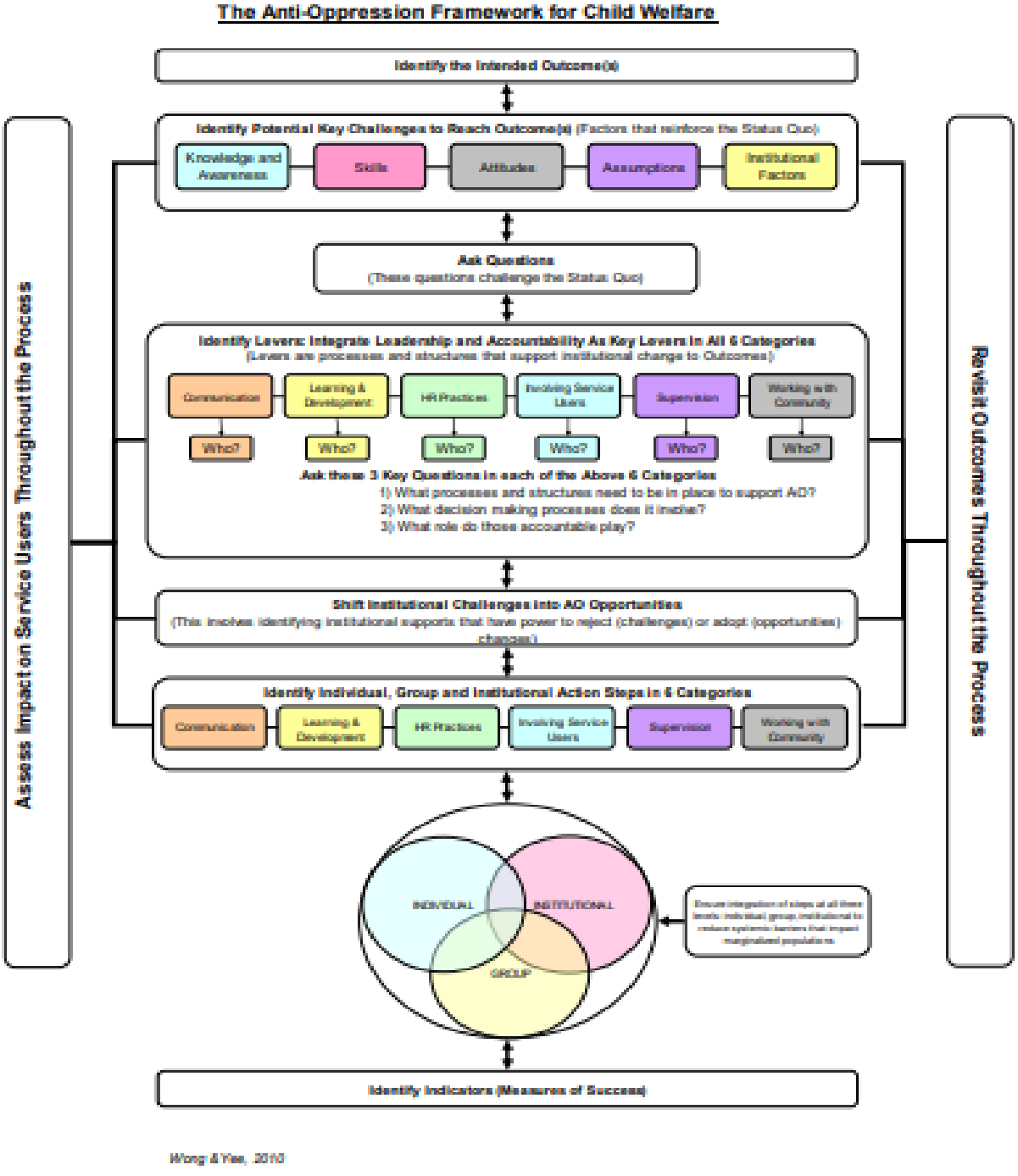
Ontario Association of Children's Aid Societies (2019)

Appendix B – Circle of Security Parent Attending To The Child's Needs



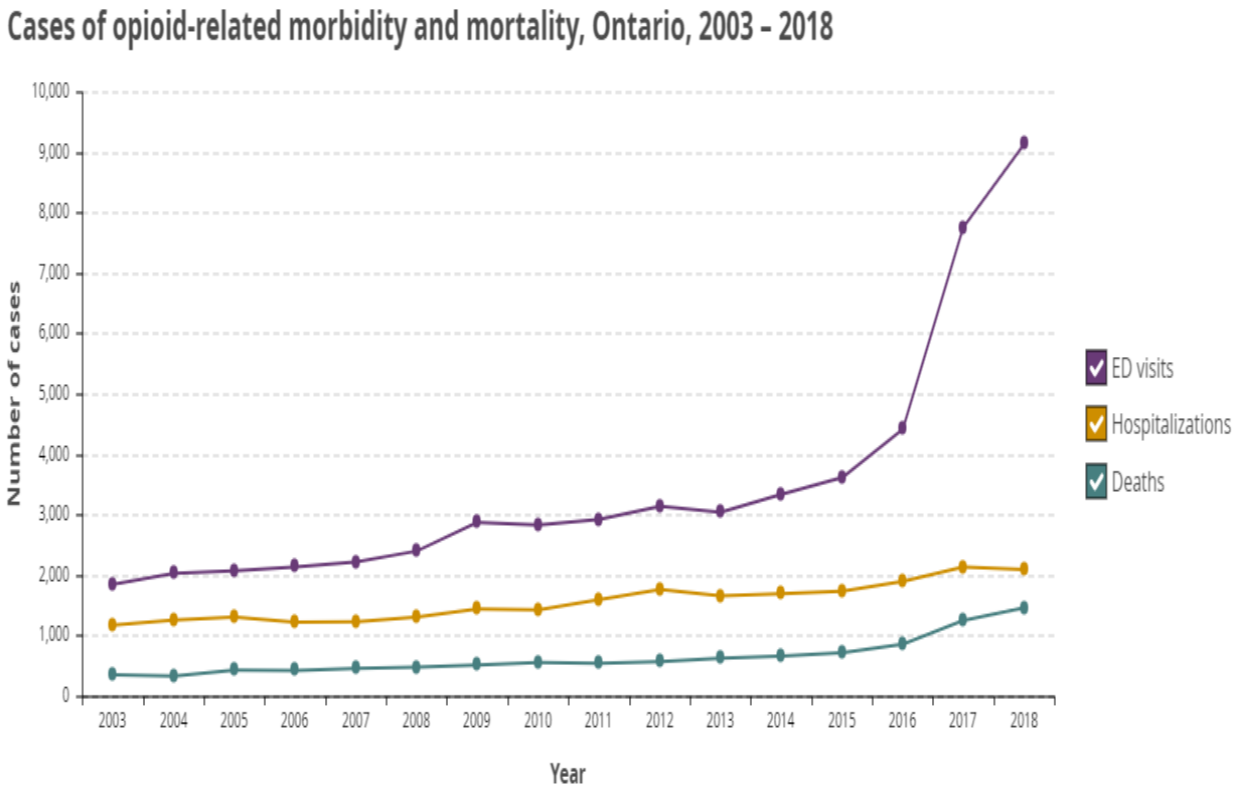
http://handsholdinghands.com.au/hhh15/wp-content/uploads/2015/03/COS-image.jpg

Appendix C – Anti-Oppressive Framework in Child Welfare, (Wong & Yee, 2010)



http://www.oacas.org/wp-content/uploads/2017/01/Framework.pdf

Appendix D – Cases of opioid-related morbidity and mortality, Ontario 2003-2018



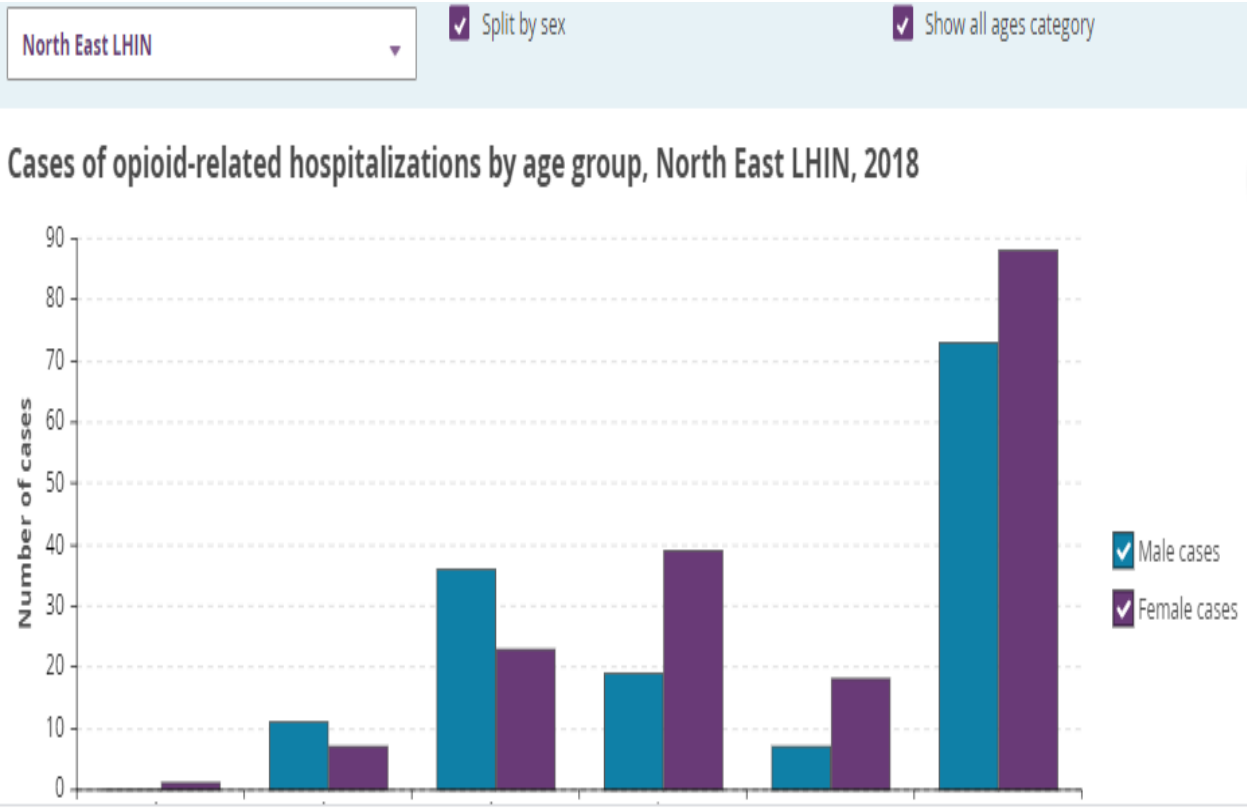
Notes:

- * Monthly and quarterly rates have been annualized for comparability between different time periods.
- Death data for 2019 should be considered as preliminary and is subject to change.

Ontario Prescription Opioid Tool - Ontario Drug Policy Research Network

http://www.publichealthontario.ca/en/data-and-analysis/substance-use/interactive-opioid-tool#/trends

Appendix E – Cases of opioid-related Hospitalizations by age group, North East LHIN, 2018



Ontario Prescription Opioid Tool - Ontario Drug Policy Research Network

https://www.publichealthontario.ca/en/data-and-analysis/substance-use/interactive-opioid-tool#/ageSex

Curriculum Vitae

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EDUCATION

Laurentian University
Master of Social Work (MSW) **Summer of 2020**
Dissertation "Mothers with Newborns with Neonatal Abstinence Syndrome

Master of Social Work Advanced Practicum
Children's Aid Society, Nipissing and Parry Sound Student, 450 Hours **Oct 2019 - Jan 2020**
My Advance Practicum in child welfare incorporated hands-on experience in child welfare and early intervention program service. The y focus was on the experiences of pregnant women and women with children who struggle with substance misuse. This practicum was under the guidance of the field supervisor Deborah Bryers, Supervisor of Early Intervention Services, and under the Supervision of Gisele Hebert, Executive Director.

Laurentian University
Honours Bachelor of Social Work, (HBSW) **April 2017**

Social Work Practicum
Assistant Research Analyst, 400 Hours **Sept 2016 - Mar 2017**
The research practicum focused on data collection, evaluating, analysis of quantitative and qualitative data for the Nipissing Poverty Reduction Education Program. This placement was under the guidance of David Plumstead, a Research Analyst at the DNSSAB.

Nipissing University
Bachelor of Arts, Women's Studies and Social Welfare (BA) **April 1998**

Canadore College
Law and Security Program Diploma **April 1995**

TEACHING EXPERIENCE

Canadian Career College
Lecturer "Family Law" Legal Assistant Program **Jan 16, 2012 - 2013**
Developed teaching material, assignments, and administered all grades

RELATED EXPERIENCE

District of Nipissing Social Services Administration Board
Ontario Works Case Manager **July 24, 2000 - present**
Maintain a caseload of approximately 145 families with Ontario Works, financial and employment assistance. I determined initial and ongoing eligibility for Ontario Works assistance under the Ontario Works Act. My position also entailed emergency, funeral and employment-related expenses.

District of Nipissing Social Services Administration Board
Ontario Works, Supervisor (various times) **2003 – Dec 2018**
I managed 11 staff members in a unionized environment that included Human Resource functions, WSIB documentation, delegated of tasks, providing training tools, administered team meetings, worked with staff to resolve conflict, hiring of new staff, meetings with the management team, senior management, Board of Directors presentation and meetings

North Bay Regional Health Centre / Nipissing Detoxification Substance Abuse Program
Addiction Worker **Oct 2013– Aug 2017**
I completed admission for Crisis Admissions, Residential Treatment Program and the Detoxification services. I completed assessments for potential addiction treatment admissions (GAINS).

Gateway Hub Committee
DNSSAB Representative **2014 - 2016**
I participated in the Gateway Hub Committee as a representative of the District of Nipissing

Social Services Administration Board. This table had representatives from different organizations in the Nipissing District. We participated in reviewing high-risk cases and determine appropriate action with community supports to provide services and resources to the individual and or family to alleviate the crisis.

Nipissing Transition House
Crisis Resource Counsellor **July 18, 2011 - 2014**
Provided support to women and their children while they resided at the Women's shelter. These families are usually fleeing from abusive relationships or are struggling with housing challenges. We provide resources to the families and guide them to obtain safe housing and financial resources.

District of Nipissing Social Services Administration Board (DNSSAB)
STEPS Home Management Committee **July 2011 to March 2016**
This committee involved with the Nipissing District Housing Corporation, Nipissing Transition House and DNSSAB. We met quarterly to review the project of the Second Stage Housing and review its progress and challenges.

Ontario Works / DNSSAB
Family Support Worker (various times) **June 2005 - 2014**
Assisting social assistance recipients with child/spousal through the Ontario Court of Justice, Administering private support agreements based on the Child Support Guidelines. I was Responsible for completion of court documents, filing and serving, and negotiating with the parties under the Family Law Act.

Ontario Works / Parry Sound District (PSDSSAB)
Ontario Works Case Manager **May 1999 - July 2000**

MEMBERSHIP

Ontario Colleges of Social Workers and Social Service Workers (OCSSWSW)