IN WHOSE BEST INTEREST? BALANCING MOTHERS' PLIGHTS AND CHILDREN'S RIGHTS IN HARM REDUCTION PROGRAMS: FRONTLINE SUPPORT WORKERS' PERSPECTIVES

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Abstract

This study explores frontline support workers' perspectives on how mothers' needs and children's rights are balanced in harm reduction programs in an urban centre in Alberta, Canada. Interviews were conducted with five (5) workers employed at harm reduction programs supporting mothers and/or children facing circumstances related to substance use, domestic violence, mental health, poverty, homelessness, and criminal justice system involvement. The interviews, along with content from publicly available (web-based) program descriptions, were analyzed through a theoretical framework that mobilizes theories of intersectional stigma (both on symbolic/interactional and structural levels). Participants revealed that intersectional stigma emerges from an abstinence-based child welfare system (namely, Children's Services (CS) in Alberta), which constitutes a major barrier to ensuring the best interests of both mothers and children. Such stigma manifests based on the intersecting identities that women hold as mothers, as substance users, as partners who face violence, as criminalized persons, and more. Experiences of these barriers disproportionately impact mothers who do not meet idealized standards of mothering—standards which seem to be upheld and reproduced by the medicalization of motherhood. These families are more vulnerable to interventions including child apprehensions, which have severe impacts for both mothers and their children. The perspectives of the frontline support workers point to the importance of a harm reduction approach as an alternative to the current harm elimination one, but identified tensions between harm reduction and harm elimination remain a barrier to balancing the best interests of both mothers and children. Despite these tensions, the participants discuss their own practices of self-awareness and reflection and point to relationship building, non-judgment, and client-centering as essential to the role of the frontline worker who adopts a harm reduction approach.

Keywords: harm reduction; harm; motherhood; children; support.

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1. Introduction

> What's most misunderstood about [addiction] is that it's the problem, when really, it's the symptom…I'll leave it at that.
>
> -Anna (Participant A)

This reflection from a frontline addiction worker who supports pregnant people and mothers moves us to question the ways in which addiction and trauma are socially constructed. Many pregnant persons and mothers live in what some may consider harmful or unsafe situations. Issues of domestic violence, substance/alcohol use, adverse mental health, and criminalization exist across all socioeconomic levels (Marcellus et al., 2015), but impoverished and racialized populations continue to be disproportionately affected as they face many barriers that stem from a long history of oppression that manifests across multiple systems. Mothers and mothers-to-be are subject to these barriers from discriminatory systems as they attempt to navigate not only their own distinct challenges and traumas, but also the stressors of parenting and meeting their children's needs. For them, the intersectional experience of parenthood, gender, and other identity factors greatly impact the way they balance their own interests with those of their children, particularly when the state is involved.

In the 1990's, programs attempting to support pregnant persons and mothers living with substance use dependencies first emerged in Canada (Nathoo et al., 2016). More programs have been created since then to provide services to this population of mothers and/or pregnant persons and their children using harm reduction approaches. A harm reduction model exists in opposition to an abstinence-based one. Rather than viewing harm elimination as the only viable option, harm reduction takes a more pragmatic and realistic approach with strategies that attempt to reduce the negative impacts of harms associated with substance use or mental health, for example, while meeting the basic and immediate needs of clients. The increasing use of harm

reduction strategies in frontline support is often seen as particularly controversial when children are involved. Harm elimination and abstinence are prioritized to seemingly protect the rights of children, but this model along with systemic problems in Canada's provincial child welfare systems have led to failures in protecting the rights of children (Canadian Coalition for the Rights of Children (CCRC), 2018). Harm elimination strategies like the removal of children from their homes are too often seen as the only option, especially for Indigenous[1] populations in Canada who are vastly overrepresented in the child welfare system that is not fulfilling its duty to provide support for vulnerable parents and children (Truth and Reconciliation Commission of Canada (TRCC), 2015a; CCRC, 2018). Although research supports the effectiveness of harm reduction strategies on population outcomes and cost benefits, sociopolitical attitudes that view such interventions as controversial have limited their implementation in Canada (Wild et al., 2017).

The recognition that children who are exposed to prolonged adversity experience stress responses that affect mental and physical health and development especially in the absence of supportive relationships (Center on the Developing Child, 2016) further complicate the moral and ethical dilemmas surrounding the adoption and acceptance of formal harm reduction approaches for mothers and their children. Considering the limited research that critically engages with the intersection of mothers' needs and their children's rights in harm reduction programs generally, and through frontline workers specifically, this study explores frontline workers' perceptions of how mothers balance their own needs with those of their children through harm reduction strategies as they live with issues of domestic violence, substance use, mental health, criminalization, and/or poverty. In order to examine such complexities, the

[1] The term Indigenous refers to First Nations, Métis, and Inuit peoples, the first inhabitants of the many territories on Turtle Island, which settlers and much of the world comes to refer to today as Canada.

following questions are addressed through feminist, constructionist, and intersectional lenses in criminology:

(1) How do frontline support workers perceive the balance of best interests for both mothers and children in harm reduction programs?

(2) How does this perception affect the focus of their own work in supporting their clients?

By better understanding both the intersection and dissonance between mothers' needs and children's rights in harm reduction programs through the perspectives of frontline workers, we can identify and address challenges, successes, and other elements that characterize the perceived experiences of pregnant persons and mothers and who face adversity. These insights can inform best practices for securing rights for both mothers and children while advocating for harm reduction approaches that acknowledge the sociohistoric environment and the construction of impoverished and racialized pregnant persons and mothers as dangerous and unfit.[2] Additionally, by deconstructing the idea of a 'good' mother through a critical drug perspective, this project contributes to a more realistic view of mothering and childhood experiences, many of which are not openly discussed or accepted. These research-informed views can potentially serve to decrease stigma and lead to more useful alternatives in support practices in the criminal justice and child welfare systems.

This study seeks to contribute simultaneously to research in social work practice and criminological literature as it attempts to recognize and give visibility to the criminalization and medicalization processes in the neoliberal era as they relate to gender and motherhood. Such

[2] Pregnant persons and mothers who hold intersecting and marginalized identities are constructed as risks to their children based on idealized standards of motherhood (see Boyd, 1999, 2019; Bromwich, 2017). This risk construction is discussed further in Chapter 2.

processes systematically reinforce elements of difference in ways that disproportionately impact those who are impoverished, racialized, and/or are using substances (Boyd, 1999; Dollar, 2019). The harms that marginalized mothers, pregnant persons, and children face, whether these relate to parental substance use, domestic violence, adverse mental health, and/or poverty, are often associated with 'crime'. A constructionist and feminist lens in criminology allows us to give visibility to the ways in which 'crime' has been conceptualized and operationalized in formal legal systems based on a history of colonialism and oppression. This oppression continues and manifests as a significant gap in barrier-free support for these populations. By exploring the practical realities of harm reduction for mothers and children based on the insights of frontline workers, this project contributes to a more critical understanding of marginalization and barriers in child welfare, health, and criminal justice systems. This understanding is necessary as we attempt to move towards a rights-centered system of support for vulnerable families.

1.1 Outline of Chapters

Following this introduction (Chapter 1), the next chapter (Chapter 2) of this thesis reviews the literature on motherhood, children's rights, and harmful circumstances in the context of the family and the neoliberal state in Canada. The intersectional dimensions of motherhood in critical feminist literature are presented before moving to a review of harm reduction literature and its limitations.[3] In the third chapter, I present the theoretical framework from which I analyzed the interviews and program descriptions.[4] This work mobilizes a theoretical framework that accounts for intersectionality and stigma on structural and symbolic levels to present a

[3] Chapter 2 reviews a wide range of literature on various topics to present a more holistic and well-informed analysis on the balance of best interests for mothers and children utilizing a harm reduction approach. While the connections between the topic areas may not be readily clear, I illustrate their interrelations and subsequent significance throughout the chapter's sections to advance the analytic findings.

[4] The primary source of data for this study is interview transcripts, although content from publicly available (web-based) program descriptions where the participants are employed constitute a secondary form/point of analysis.

holistic analysis of the interview data. The fourth chapter outlines the methodological approach used in this research, particularly the research design and methods used for data collection and analysis as well as the wider epistemological placement of this project and the limitations of the research study.

The analysis is presented thematically in three chapters. In Chapter 5, I 'set the (analytic) stage' with a contextualized overview of the five (5) participants and the four (4) programs in which they work.[5] Content from publicly available (web-based) program descriptions and mandates is analyzed in light of the participants' own descriptions of each program from their respective interviews. Clients' needs and general demographics[6] are introduced based on the participants' perceptions and the programs' content related to eligibility/areas of support. In Chapter 6, the theme of harm reduction as "not just a bag of stuff"[7] is explicated based on the definitions and perceived importance of harm reduction approaches according to the participants. Additionally, the ways in which the frontline support workers' practice self-awareness and reflection within harm reduction models are comparatively analyzed. The main analytic chapter related to intersectional stigma (Chapter 7) focuses on the theme of identifying barriers and navigating tensions through subthemes of abstinence-based barriers as intersectional stigma, mirrored tensions between harm reduction, elimination and balancing best interests for both mothers and children, and navigating tensions to overcome barriers. This work concludes in Chapter 8 with final remarks on this study's findings and the implications for mothers and children, as well as on the limitations and recommendations for future research.

[5] Two (2) of the participants (Participants C and D) are employed with the same program, as noted in Chapter 5.
[6] The general demographics of the clients are based solely on the participants' perceptions and not on program data, so there are limitations to the reliability and conclusions that can be drawn; however, perceived demographics are based on the frontline support workers' experiences and they are often supported in the literature, so they merit consideration.
[7] Excerpt of a quote taken from Participant A's interview transcript.

2. Literature Review

The chapter begins by exploring constructions of motherhood in a North American context and discussing the implications of such constructions for those who are marginalized. The duality of motherhood as both a powerful possibility and a co-opted institution is presented through feminist literature that considers historical, sociopolitical, and economic landscapes that have shaped and widened gender inequalities, especially for those who do meet normalized standards of motherhood in neoliberal times. The tensions between motherhood and other identities, particularly identities that are linked with harmful consequences like substance use, are discussed as are the responses that attempt to prevent, eliminate, or reduce those harmful consequences. A review of the literature on children's rights in relation to mothering, harm, and child welfare is then provided to better contextualize harm reduction and its controversies when it is applied in family settings.[8]

Exploring the emergence of harm reduction as well as the moral and legal concerns related to child welfare when utilizing harm reduction approaches is central to this study's main questions. Harm reduction is presented in the literature as a powerful alternative to abstinence-based models, but the relatively few programs utilizing its approaches in Canada are subject to more intense evaluations and requirements despite significant evidence in support of its benefits (Hathaway and Tousaw, 2008; Wild et al., 2017).[9] Moreover, there is a gap in literature that critically assesses whether harm reduction is truly applied in practice and if it is, how those practices can be useful in the context of larger systems that utilize an opposing model based on

[8] I acknowledge that this review draws from several bodies of literature on a wide range of topics which may not seem immediately relevant or interrelated. However, they have been selected intentionally to serve as a means of bringing topics into conversation with one another to advance a more comprehensive analysis of the (in)compatibility and balance between mothers' plights and children's rights.

[9] Evidence in support of harm reduction is presented in more detail in section 2.6. For further reading, see Ritter and Cameron (2006), Kimber et al. (2010).

abstinence (i.e., harm elimination) as the priority. At the end of this chapter, I discuss the gap in prior research that explores issues related to harm reduction, motherhood, and children's rights through the perspectives of frontline workers and I then explain how this project contributes to existing research in these areas.

2.1 Motherhood "Superimposed"[10]

> I try to distinguish between two meanings of motherhood, one superimposed on the other: the *potential relationship* of any woman to her powers of reproduction and to children; and the *institution*, which aims at ensuring that that potential—and all women—shall remain under male control.
>
> -Adrienne Rich

Rich (1986) refers to motherhood as both experience and institution—the former being the possibility of motherhood as a powerful experience in a woman's life. For the latter, Rich suggests a superimposed manifestation of the expectation and process of mothering which takes away women's control over their own bodies and grasps at every facet of their lives and choices. In the Western world, there is a powerful dichotomous construction of mothers as being either good or bad (Miller et al., 2017; Foulkes, 2018). This construction is visible in the media, textbooks, parenting manuals, and other popular culture and it is confounded with heteronormative, White, middle-class, and sober identities (Campbell, 2000; Taylor, 2011; Foulkes, 2018; Boyd, 2019). Such a construction of motherhood is shaped by dominant patriarchal theological histories and religious beliefs in North America, which perpetuate essentialized notions of womanhood and motherhood (Cooey, 1999; Chittister, 2004; Bonavoglia, 2005).

[10] The title of this section and the subsequent excerpt that follows it must be credited to Adrienne Rich (see *Of Woman Born*, 1986, p. 13).

Motherhood in North America has come to be seen as a 'natural' part of womanhood and the most essential manifestation of femininity (DiQuinzio, 1999). Historically, motherhood has been "romanticized" as a selfless expression of love (Boyd, 1999, p. 8). Women have been expected to be nurturing and completely devoted to their children in North America where intensive mothering serves as the dominant mothering ideology (Hays, 1996). Such practices are guided by child-rearing experts and are typically emotionally and financially intense, as the name denotes. Since these standards are based on cultural and economic models of White, heterosexual, and middle-class mothers, they fail to represent and accept parenting styles that exist for different cultural groups which becomes the basis for many discriminatory outcomes for women who do not meet normative standards (Hays, 1996; Budig and England, 2001; Ridgeway and Correll, 2004).

Pregnant persons and mothers who use substances and/or alcohol, and those who live with violence, mental health issues, (dis)ability, poverty, or criminal justice involvement, are seldom considered to be ideal mothers and they continue to be constructed as unfit, dangerous, and a risk to their children's well-being (McKeen, 2009; Kilty and Dej, 2012; Pollack, 2010; Boyd, 2019). These populations that the state constructs as risky have been subject to a long history of oppression, injustice, and criminalization—for Indigenous and racialized people in Canada, this stems from colonial policies[11] and practices that continue to manifest today (Campbell, 2017; Boyd, 2019; Ritland et al., 2021).[12]

[11] The influence of Catholic and Protestant religions on these policies are significant in Canada and particularly evident in Residential Schools. Separating children from their families in a process of "aggressive assimilation" has culminated in a cultural and physical genocide with injustices still being uncovered and felt today, as they will be well into the future (TRCC, 2015b, p. 105) and they are premised on racist perceptions of White supremacy that view Indigenous people as incapable of parenting their own children in alignment with their cultures and beliefs.

[12] Since this study is based in Canada, and thus in the 'West' and North America, I review the literature and history of mothering in this Western-centric context. While it is beyond the scope of this study, it would be important to compare Canada's sociohistorical context to that of other countries in future research to allow for a deeper understanding.

The broader discourse on motherhood as it has been shaped (and shifted) throughout history will be reviewed in order to better contextualize the implications of such discourse for people who are pregnant or mothering while using substances and living in circumstances that are linked to harmful consequences and for their children.

2.2 A Maternal Dilemma in Neoliberal Times

A changing economic landscape and the efforts of feminists to affect public policy led to an increase in women's participation in the labour force in Canada since the 1970's (Cohen and Pulkingham, 2009). Attempts to move towards gender equality highlighted tensions between traditional gender roles for women and new identities. Such tensions have been identified as a kind of maternal dilemma which questions whether it is possible to be both a mother and an autonomous individual (Allen, 2005). For Allen, this dilemma is a "most intractable [problem]" for women in the West (p. 1). It is evident that there remains a heavier burden on women than men as parents to take care of children, which limits their economic, social, political, and cultural lives (Rich, 1986; Hays, 1996; Boyd, 1999; Allen, 2005). In Canada, the efforts of feminists to enhance the status of women in post-war times required the acknowledgment of the heavier burden that women hold, as well as a plan for public policy changes that improved conditions for all women (Cohen and Pulkingham, 2009).[13]

The notion that women are primary caregivers and have a unique and primary responsibility for their children which prevents them from enjoying equality and equal access to their own lives (Berry, 1993; Michel, 1999; Cohen and Pulkingham, 2009) was acknowledged by

[13] The period after the second world war from 1945 to 1989 encompasses 'post-war' times in Canada, but the second wave of feminism is considered to have occurred in the 1960's until well into the 1970's in the US and Canada (Rebick, 2005; Molony and Nelson, 2017).

the Royal Commission on the Status of Women (RCSW, 1970) in Canada. Founded in 1967, the RCSW held as its mandate the following:

> [to] inquire into the status of women in Canada […] to ensure for women equal opportunities with men in all aspects of Canadian society…
>
> -Report of the RCSW, 1970

The RCSW report[14] published in December of 1970 provided 167 policy recommendations to address various issues for women.[15] Despite well-intentioned goals, this report, and others like it, which are increasingly seen in through national and global campaigns pushing for gender equality, have served to create a façade of equality and empowerment that continues to render the work and unique burden of responsibility that women carry invisible.

2.2.1 Free Market Feminism[16]: Neoliberalism's Gender 'Equality'

In the last several decades, neoliberalism has emerged as the dominant political rationality in North America and beyond. Such a neoliberal era is characterized by increased globalization and economic models that rely on individualization (Clarke, 2008; Venugopal, 2015). The burdens of circumstance are placed on the individual, which allows the state to justify their lack of social support—a fact that is particularly concerning for women (Güney-Frahm, 2020). Individualized efforts to overcome inequality and include women in the labour force by increasing productivity emerged over the past few decades and continue to be seen in development models that target the historical exclusion of women (Wilson, 2015). Rather than

[14] The digitized edition of the 1970 RCSW Report can be found via the Government of Canada's website here: https://publications.gc.ca/collections/collection_2014/priv/CP32-96-1970-1-eng.pdf

[15] The recommendations in the RCSW report focused on eight categories of issues including poverty, women in the family, and childcare allowances. More information on the report can be found through the Canadian government's website here: https://women-gender-equality.canada.ca/en/commemorations-celebrations/royal-commission-status-women-canada.html. For more critical commentary related to the impacts of the report since its publication, see Cohen and Pulkingham (2009) from page 6 onward.

[16] The term 'free market feminism', also referred to as mainstream or hegemonic feminism by the author, is attributed to Eisenstein's (2016) *Feminism Seduced.* For a more detailed discussion of this topic, see this work.

moving towards gender equality, various literature supports the idea that such efforts have widened inequalities under the guise of empowerment and feminism (Prügl, 2014; Wilson, 2015; Eisenstein, 2016; Güney-Frahm, 2020). Some research has explored women's lived experiences with what Blair-Loy (2003) describes as "competing devotions" of valuing motherhood against work successes and has shown that identities of worker and mother are not necessarily in competition in some women's experiences (e.g., McQuillan et al., 2008). Other literature illuminates wider contexts related to mainstream feminism in neoliberal times to alert us to the false sense of equality that international organizations are striving towards (see Roberts and Soederberg, 2012; Eisenstein, 2016; Rottenberg, 2019). The following quote is reminiscent of the confusion that a façade of equality and development brings for this wave of feminism:

> As feminists, should we not rejoice? Does it not appear that, at long last, the powers that be have begun to recognize the economic and social contributions of women? Is this not what feminists have been pleading for? Not so fast!
>
> -Hester Eisenstein[17]

Not so fast, indeed. With the help of organizations that advocate on behalf of gender equality and development, women entering the labour force are taking on added responsibilities while the same organizations that attempt to 'empower' them continue to overlook the unequal burden of care that they hold. Moreover, these demands for equal treatment have amplified discriminatory impacts for women and mothers who are marginalized (Marcellus et al., 2018; Foulkes, 2018).

In order to fully understand the impact of the social construction of motherhood on women (and women who are marginalized in particular) and the relationship of such a construction to child protection and ensuring the best interests of the child, it is necessary to

[17] The quoted content is an excerpt from Eisenstein (2016), p. ix.

further explore historical and economic contexts in which those intertwined constructions and relationships have existed since the Industrial Revolution.

2.2.2 Bad Moms, Worse Women: Medicalizing Motherhood[18]

Since the Industrial Revolution, we can observe the subtle changes in the construction of motherhood by considering the state's changing relationship with the family:

> Child rearing was becoming a national duty, not just a moral one.
>
> -Anna Davin[19]

Davin (2019) alludes to the nationalization of child rearing and child protection which created space for the need to instruct and survey mothers on all matters relating to health and parenting, allowing blame for social problems to be placed on mothers rather than on the state. Boyd (1999) notes that such predicaments are reminiscent of our time's ideological hegemony where social problems are reconstructed as both public and medical.

The medicalization of pregnancy and motherhood have served to create normative expectations that transform women's bodies into a sort of machine or technology (Rothman, 2000)—in other words, we see a transformation of the woman from a subject into an object (Thurer, 1994). This view of women's bodies as technologies is particularly evident in impassioned arguments and policies against pregnancy termination, which are largely shaped by religious justifications, whereby women who terminate pregnancies are seen as "deviant reproductive decision-makers" or bad women (MacLeod et al., 2020, p. 34). The Roman Catholic Church's stance on pregnancy termination is clearly one of disapproval (Storrow, 2011); furthermore, religious institutions and groups in the West who espouse such sentiments

[18] The impact of medicalization on children is explored further in section 2.4.3.
[19] The quoted content is an excerpt from Davin (2019), p. 91.

paint women who make decisions about their own bodies and lives as failures, whether these decisions relate to pregnancy and/or substance use.[20]

Women who use substances are subject to what Boyd (1999) refers to as a change in status when they become pregnant. They are closely surveyed and assessed in terms of parental capabilities and in keeping with the neoliberal and capitalist ideology, any perceived failings are attributed to them as individuals rather than to wider society and the lack of support the state provides.[21] They are seen to be 'bad' mothers, and even worse, women who fall outside the margins of normative standards (Miller et al., 2017)—not only the standards of motherhood, but also the standards of womanhood (DiQuinzio, 1999). This marginalization renders them even more vulnerable to state intervention as justified by an individualistic public health domain (Veenstra and Keenan, 2017; Boyd, 2019).

The ways that mothers who use substances conceptualize motherhood in relation to mainstream expectations has been explored in the literature (see Baker and Carson, 1999; Boyd, 1999; Kilty and Dej, 2012; Grundetjern, 2018), but the impact of those expectations on the lived experiences of those mothers and their relationship with their children is less visible in social science research. Martin (2019) notes that more work needs to be done to further explore the interplay between identity negotiation in relation to normative standards and the day-to-day experiences of motherhood/the relationship that mothers have with their children.

[20] See Gervais and Watson (2018) for further nuances in this regard and a reference to Chittister as quoted by Bonavoglia (2005) on the contradictory position of the Catholic Church and the differential perspectives on when 'life' is in the hands of men compared to when it is the hands of women.
[21] The gendered implications of capitalism and neoliberalism are explored further in section 2.2.1 (Free market feminism: Neoliberalism's gender 'equality' and 2.2.2 (Bad moms, worse women: Medicalizing motherhood).

2.3 Identity and Intersections of Trauma, Motherhood, Harm

As feminist understandings evolve, there is an increasing awareness that experiences are not the same for all women, and they are not the same for all mothers (Rich, 1986; Foulkes, 2018). Intersections of gender, race, and class, as well as other identity categories related to victimization and trauma, vastly impact the ability of women to meet the standards of essential motherhood; moreover, these intersections shape the ways in which mothers experience the ideology of motherhood (Hays, 1996).[22] Crenshaw (1989) explains that experience is not the sum of both race and sex combined, but rather the relation between the two as they exist together—their intersection (p. 141). Discrimination through the combined effects of practices and policies occurs because of sex and race, but discrimination is also experienced separately from a sum of these categories (p. 149).[23] Her criticism of feminist theory is still relevant: the premise of the white female experience, which becomes the universal female experience, breeds faulty theories that do not account for all (intersectional) experiences (p. 56). Class privilege or lack thereof, for example, is another identity category that requires consideration, as it has been shown to impact the experiences of mothers and their children—at a basic level, class impacts a mother's ability to enter the workforce and care for her children. When other factors intersect with class, there is a marked change in experience. It is the interaction, not the sum, of these identity factors that impact experience and further impact perceptions on motherhood.

Intersectionality as an important element that shapes mothering experiences has been adopted in theoretical frameworks of various literature related to race, gender, and class (see

[22] See Hays (1996) for a more in-depth discussion of cultural contradictions that impact how women experience the ideology of mothering and also Taylor (2011) for a more recent application of cultural contradictions and intersections of race, gender, and class as they relate to motherhood.
[23] By using examples of antidiscrimination cases that have different issues and outcomes, Crenshaw (1989) illustrates limitations of single-axis analysis which assumes that exclusion is "unidirectional," that is a product of either race or sex, but not intersections of both (pp. 148-149).

Zinn, 1990; McDonald, 1997; Lareau, 2003; Taylor, 2011; Kilty and Dej, 2012). More critical work that considers the impacts of interlocking systems of oppression on the lived experience of mothers who are marginalized acknowledges that intersectionality is inextricably linked to experience (see Pollack, 2010; Kilty, 2011; Kilty and Dej, 2012; Boyd, 2019). Although there is a focus on categories of race, gender, and class (and justifiably so), the different identities of women as mothers, women as substance users, women as criminalized persons (or incarcerated persons—see Kilty and Dej, 2012), and women as partners in unhealthy (or violent) relationships merit exploration. This study attempts to add to a small but growing base of literature that considers the aforementioned identities as distinct, yet intersectional. It is important to explore the experiences of women who are criminalized and victimized, as they belong to a marginalized group that is uniquely stigmatized and perceived as unable to be 'good' mothers.

Although the complexity of theoretical research increases when exploring multiple variables related to the intersections of trauma, gender, substance use, and domestic violence, previous quantitative and qualitative research has demonstrated that these circumstances are often linked and do not exist as separate entities (see Poole et al., 2008; Hughes et al., 2011; Hovey et al., 2020). Additionally, people who have concurrent disorders tend to receive poorer quality of support services and demonstrate worse treatment and recovery outcomes (Khan, 2017). There is a growing awareness that concurrent disorders, also known as co-occurring disorders or dual diagnoses, are more prevalent among vulnerable populations. Additionally, experiences of trauma increase the likelihood that a person will develop a problematic substance use disorder.

There is a wide base of research that shows a demonstrable link between Post Traumatic Stress Disorder (PTSD) and alcohol and substance use dependencies (see Cottler et al., 1992;

Driessen et al., 2008; Johnson et al., 2010). Literature that supports the role of trauma as a factor in future life experiences justifies the need for more critical research that considers the gendered interplay of trauma, substance use, criminalization, and violence on mothers and their children.[24] Because there are seemingly distinct bases of literature that exist on substance use and domestic violence respectively in the context of motherhood and children's rights, the following subsections (sections 2.3.1 and 2.3.2) present separate findings that come to similar conclusions regarding overall unmet needs of mothers in Canada. Following this focused discussion related to mothers, the subsequent section (section 2.4) includes a more directed focus on children and their rights and how their compatibility with the interests of women is reflected in the literature.

2.3.1 Substance Use[25]

Women's paths to and through substance use that have been shown to be different from men's (Baker and Carson, 1999; Hines, 2013) and based on quantitative studies, women are more likely to have had traumatic experiences, which increases their risk of developing substance use disorders (Torchalla et al., 2012; Agterberg et al., 2020). Research on this topic tends to utilize quantitative methods[26] to evaluate outcomes based on demographics and other numeric data, but there are also qualitative studies that shed light on the lived experiences of pregnant women and mothers who struggle with substance use and/or criminalization (Baker and

[24] An important and relevant example of the impacts of trauma on mothers are children can be seen in Indigenous families in Canada that continue to face cycles of intergenerational trauma. Unresolved historical trauma stemming from Canada's history of colonialism and cultural genocide (TRCC, 2015a) is linked to maternal substance use, Post-Traumatic Stress Disorder, anger, family violence, and suicide—such struggles mean these mothers are seen as unfit by the child welfare system, which then reproduces and enforces cycles of harm for Indigenous children and mothers by removing children from their homes rather than providing them with more understanding and effective support (Caldwell and Sinha, 2020; Ritland et al., 2021).

[25] While I refer to 'substance use' generally, there are complexities and nuances surrounding the types of substances used and their impacts during pregnancy.

[26] While I note that many studies tend to use quantitative methods, I acknowledge the inherent issues of a purely technical understanding of research approaches, which do not take into account broader epistemological considerations. See section 4.2 of this work for more detail.

Carson, 1999; Kilty and Dej, 2012; Marcellus et al., 2015; Stone, 2015). The latter literature tends to problematize identity and more specifically, the oversimplification of identity as we see complex processes of renegotiation with which women contend. For example, Baker and Carson (1999) interviewed seventeen substance-using women to gain insight into their perceptions of motherhood. Unlike widespread conclusions, these women saw themselves as "caring and committed" mothers (p. 349). All women saw their identities as mothers as central and fundamental to their lives and they expressed deep care and commitment for their children—their substance use was a means of coping rather than a means of enjoyment.

Women's abilities to renegotiate their identities, especially in times of adversity, seems to allow them to remain hopeful and exercise some power over their addictions (Kilty and Dej, 2012, p. 13). Although substance use and criminal justice system involvement are often seen by research participants as incompatible with the idea of a 'good' mother, nuances exist whereby some mothers re-form their identities around their conceptualization of motherhood as a type of persisting or enduring point of focus that—in theory— serves to propel them towards change and redeem them from their perceived failings (Baker and Carson, 1999; Maruna; 2001; Kilty and Dej, 2012). In practice, though, there is an inherent danger in 'tying' transformation and hope to the "anchor" of motherhood , which Kilty and Dej clearly explain in the following excerpt from their 2012 study with former female prisoners who are mothers who have used substances:

> The danger in "anchoring" identity to an essentialized conceptualization of motherhood is that it may create a feedback loop of abstaining from drugs "to be a good mom," while at the same time using drugs to cope with feelings of inadequacy in that role.
>
> -Jennifer M. Kilty and Erin Dej[27]

[27] The quoted content is an excerpt from Kilty and Dej (2012), p. 11.

The insight above suggests that using motherhood as a means of promoting recovery may not be useful because of the immense pressures that women are under to measure up to both internal and external notions of essential motherhood. The life-history interviews of the twenty-two formerly incarcerated women in Kilty and Dej's (2012) study point to surveillance, both from others and from the participants themselves, leading women to constantly compare themselves to others and place themselves on a mothering hierarchy (p. 18). This study and others (see Boyd, 1999; Hannah-Moffat, 2000; Veenstra and Keenan, 2017; Boyd, 2019) support the idea that popular discourses of motherhood on which criminal justice, penal, and child welfare systems and policies are built fail to take into account interlocking systems of oppression that lead to disadvantage and have harmful implications for women, particularly those who use substances and are otherwise criminalized and marginalized. It is clear that the contemporary definition of a 'good mother' exists in direct opposition to criminalized mothers and mothers who use substances.

There is a wealth of literature on substance use during pregnancy and (maternal) parenting that focuses on the inherent failings of mothers who use substances and the harmful impacts on children (see Densen-Gerber and Rohrs, 1973; Peak and Del Papa, 1993; Buckingham-Howes et al., 2012); yet a gap exists with regards to a consideration of critical aspects related to oppression and dynamics of race, gender, and class. More critical work that focuses on the experiences of mothers who use substances tends to come to conclusions similar to those of Baker and Carson (1999) in terms of the centrality of motherhood (as identity) in women's lives (see Rosenbaum, 1979; Rhodes et al., 2010; Silva et al., 2013; Boyd, 2019; Holt and French, 2020). Such literature supports the idea that women can use substances and simultaneously care for their children, while also acknowledging the gendered responsibility that

women have for child rearing which leads many of them to experience immense pressure and subsequent feelings of shame and guilt.[28] These feelings are amplified as child welfare, health, and criminal justice systems aim to monitor, criminalize, and punish women who use substances, particularly when those women are pregnant or parenting (Campbell, 2017).

Women who use substances are more vulnerable to other harms related to mental and physical health, domestic violence, and poverty (Covington, 2008); additionally, women in violent relationships are more likely to use substances, yet services tend to focus on singular harms related to either substance use or domestic violence despite evidence of their intersectional relationship (Macy and Goodbourn, 2012; Hovey et al., 2020). Given the intersectional relationship between substance use and domestic violence for women and the impacts of violence in the home on women and children, it is relevant to review the literature on domestic violence more broadly, but also within research that considers its relationship with substance use.

2.3.2 Women, Mothering, and Domestic Violence

Recent estimates show that one in three women have experienced physical or sexual violence, either by an intimate partner, non-partner, or both (World Health Organization (WHO), 2021). Data from Canada also shows that women are more likely to experience intimate partner violence than men (Burczycka, 2016). Violence against women gained attention in Canada and the United States during the second wave of feminism in North America where it became and continues to be constructed as a criminal justice issue; unfortunately, responses that have largely

[28] While it is possible for mothers who use substances to care for their children, it is important to highlight the potential for harmful consequences, both when children remain in their homes and when they are removed from their homes and placed in alternative care settings, such as foster care. I acknowledge the complexity of these issues and explore them further in section 7.1.2 of this work (They just lost hope": Birth alerts, apprehensions as structural stigma).

criminalized domestic violence since the 1970's have not been successful in preventing or addressing the problem (Bailey, 2010; Abraham and Tastsoglou, 2016).

Bruckert and Law (2018) explain that earlier explanations of violence against women were largely focused on "pathologizing" women and their failures to make good choices in their own lives through a narrative of the battered woman syndrome (p. 138). Although the construction of the 'battered woman' as a passive victim in need of protection persists today (Goodmark, 2008), explanations of domestic violence have come to include more critical theories that acknowledge factors outside of the individual. Such critical literature demonstrates that the high prevalence of violence against women is deeply linked to wider social and cultural structures that oppress women (Abraham and Tastsoglou, 2016). These structures have been acknowledged in academic work as stemming from (intersections of) fiscal inequality, racism, sexism, and colonialism (see Drakich and Guberman, 1988; Michalski, 2004; Bruckert and Law, 2018).

The significant impact of Canada's failures is seen in the disproportionate consequences of flawed domestic violence policies for marginalized women. Intersectional factors related to race, class, citizenship status, religion, geographic region, ability, and sexuality must be considered as they compound the harms that women experience and they greatly shape those experiences (Collins, 1998; Cottrell et al., 2009; Parson et al., 2016; van der Heijden et al., 2019). From this perspective, the criminal justice system's failures can be attributed to misunderstandings of domestic violence and systemic gaps that do not address the structural inequalities that enable cycles of violence against women to occur and continue (Bailey, 2010; Abraham and Tastsoglou, 2016).

Along with the criminal justice system, domestic violence is of particular concern to the child welfare system because of the impact of violence on children. The child welfare system emerges in this thesis research as a central element that shapes the balancing of best interests for both mothers and children. The following sections review the literature related to children's rights and child welfare against the backdrop of motherhood and women's 'plights' as they have been discussed in the previous sections. Collectively, these reviews of the various bodies of literature serve to illuminate the tensions between mother's plights and children's rights in harm reduction programs and, more notably, within the wider child welfare system in which these programs are bound/exist.

2.4 Children's Rights and Child Welfare[29]

The rights of children have been recognized by the United Nations (UN) through the *Convention on the Rights of the Child* (CRC) (Office of the High Commissioner for Human Rights (OHCHR, 1989). Canada is among the 196 countries that have ratified the *Convention*. Article 18 recognizes that parents have a responsibility to act in the best interest of the child to ensure their healthy upbringing and development.[30] The state must also take action to protect children from violence, abuse, neglect, maltreatment, and exploitation under article 19. There is increasing awareness that children have inherent rights not only to having basic needs met, but also to expressing themselves, playing, learning, and more regardless of their ability, religion, gender, ethnicity, or any other demographic factors (OHCHR, 1989). The global adoption of policies protecting children from violent discipline in schools and homes is one such example of

[29] Child welfare denoted in this title and as it is discussed in the following section is meant to describe both the well-being of children, i.e., their welfare, and also the institution of child welfare, i.e., the child welfare system.
[30] The *Convention of the Rights of the Child* (OHCHR, 1989) in its entirety is accessible through the following link: https://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf.

the increasing recognition of children's rights and they are often seen to stem from the women's movement (Nyseth Brehm and Boyle, 2018).

2.4.1 The (In)Compatibility of Children's Rights and Mothers' Interests

An increase in anti-corporal punishment policies starting in the 1990's coincides with the adoption of the *Convention* in 1989; additionally, a historical analysis of more than 150 countries from 1950 to 2011 showed a correlation between women and children's issues, suggesting that preventing violence against children is part of a feminist framework (Nyseth Brehm and Boyle, 2018). The recognition of children's rights stems from struggles for women's rights; moreover, women have historically been advocates for children's needs and interests, which are closely linked to their own (Minow, 1986).[31]

Minow sees children's rights through a feminist lens that prioritizes connection and social relationships. Other literature has pointed to tensions between children's rights and women's interests. In North America specifically, the respective interests of mothers and children are often seen as separate and conflicting entities (Kasinsky, 1994). This separation is evidenced in literature that explores how mothers have reconciled their own interests with those of their children in a changing political and economic landscape (Berry, 1993; Michel, 1999; Allen, 2005). These tensions are also seen in the child welfare system, which tends to conceptualize child welfare itself as a struggle between the state and the family (Lessard, 2001). Given such a conceptualization, it is important to consider the CRC's explication of parental responsibility and state duty in Articles 18 and 19 respectively, not as adversaries, but rather as dual and

[31] Children's interests are seen to be of primary concern and with good reason. Children are dependent and rely on others for their care; however, the way that society tends to construct that primacy is by conceptualizing the protection of children as incompatible with the interests of women. In this section, I explore such a conceptualization and reconsider how by taking better care of mothers and their needs, children's needs are more likely to be met.

complimentary means of ensuring the best interests of children; yet they have been largely operationalized based on the incompatibility between mothers' and children's interests.[32] A question that arises in the literature that focuses on the potential incongruence between mothers' interests and the rights of children is whether parents have fundamental rights.

2.4.2 Parental Rights or Responsibilities?

Research that explores the issue of parental rights and responsibilities affirms the responsibilities of parents to act in accordance with the best interests of the child (see Bridgeman, 2007; Howe, 2001). For example, Howe (2001) argues that it is children who have fundamental rights, not their parents. While parents do have rights as individuals, as parents they have duties and responsibilities to act in the best interests of their children and to provide adequately for their healthy development and any parental rights depend on whether these responsibilities are fulfilled. The legal conceptualization of best interests of the child in Canada can be seen in the Supreme Court of Canada's (SCC) 1995 decision in *B. (R.) v. Children's Aid Society of Metropolitan Toronto* [1995] where the concept of 'best interests' is applied to the healthcare of the child.[33]

[32] Recall that according to the CRC, parents have a responsibility to act in the best interests of their children and to provide for their healthy development and the state has a duty to intervene in order to ensure the protection and safety of children (OHCHR, 1989).

[33] A more recent case in Alberta demonstrates the complexities related to the legal operationalization of the best interests of the child, particularly in the realm of medical care. SCC precedent was applied in 2016 to the case of parents David and Collet Stephan who were charged and convicted with failing to provide their 19-month-old son, Ezekial, with the necessaries of life (Grant, 2021a). The child in question died in 2012 from meningitis and it was alleged that his parents did not seek medical treatment in a timely manner which could have saved his life, instead attempting to treat the infection with natural remedies (Graveland, 2016). The Stephan's were convicted in 2016, but on appeal, the SCC ordered a new (second) trial for procedural reason whereby the trial judge did not properly explain *mens rea* of offence to the jury (*R. v. Stephan* [2018]). They were acquitted in the second trial, although that verdict was overturned upon Crown appeal. The parents have now appealed that decision and are awaiting a response from the Supreme Court who must decide if they will hear the case (Grant, 2021b). In the meantime, the Crown has stayed the charges against the parents—in other words, there are no plans for a third trial as it stands, which is said to be due to the weight (or lack thereof) of the available evidence (Vogt, 2021).

The SCC ruled that parents do not have the right to determine their child's medical treatment when it may cause harm to the child; in this case, the parents' attempted to refuse blood transfusions for their child on the grounds of religious freedom. This decision had wider implications related to the best interests of children both in healthcare and beyond. Four of the nine Supreme Court Justices argued that section 7 of the Canadian *Charter of Rights and Freedoms* [*Constitution Act,* 1982] includes a parent's right to make fundamental decisions for a child, as there is a presumption that they are acting in the best interest of the child. The other Justices hesitated to make such affirmations, as these would potentially be incompatible with the rights of the child to assume that parents will act in the best interests of children.

The tensions between children's rights and parental responsibilities are evident in legal realms, but they also emerge in academic literature as they relate to sexual orientation and queerness, education—sexual and otherwise, and children who sexually offend (see Erlings, 2016; Gervais and Romano, 2018; Ammaturo, 2019). Research affirms the complexity of parental culpability and parent-child relationships and suggests that this relationship is bi-directional—parents are also impacted by their children's behaviour (Henricson, 2008; Gervais and Romano, 2018). The significant limitation of certain research on this topic is that policy analysis and suggestions for amendments do not explore the experiences of children. Given that children's perspectives are often missing in research on child welfare practices, it becomes clear that their perceptions have not been considered fully and the work is not inclusive in the ways that it should aim to be (Cossar et al., 2014). The lived experiences of those involved is key to understanding policy implications and fulfilling the rights of children; additionally, children have the right to have their voices heard in accordance with their age and maturity level under article 12 of the CRC (OHCHR, 1989; see Cashmore, 2002; Skauge et al., 2021).

In light of the recognition of children's rights and the coinciding parental and state responsibilities, it becomes important to acknowledge that children do not have the same access to their rights. Based on class location alone, there are differences in how mothers and children experience their (quality of) lives based on the resources that women have and their access to childcare (Lareau, 2003; Taylor, 2011). Using observational research, Lareau (2003) finds "invisible but powerful" ways that social class impacts life experience (p. 3). Many have rejected the notion of 'the American Dream' and the parallel belief that all children have equal opportunities by employing a more realistic and critical lens that brings into focus the systems of oppression and inequalities that affect life outcomes of those who fall outside of White middle- and upper-class margins (Lareau 2002, 2003; Veenstra and Keenan, 2017; Caldwell and Sinha, 2020).

2.4.3 Harm with Children Involved: Examining Neuroscience, Development, and Risk

There is a wide research base that attempts to examine the impacts of various circumstances (e.g., prenatal exposure to substances, parental substance use, mental health, criminalization, poverty, and domestic violence) on children (e.g., Edleson, 1999; Kaukinen et al., 2016; Fusco, 2017). For example, studies show that substance use during pregnancy has been linked to harmful outcomes for women and children that vary based on substance type and frequency of use (as noted by Marcellus et al., 2018). While the intentions of such research are to protect children—thus constituting an important and significant area of study—neuroscience emerges from a biopsychosocial model which holds a characteristically positivist approach that fails to consider its own discriminatory nature (Leifer, 2001; Rimke, 2010). By examining the wider context in which neurobiological research on child development has been shaped, more critical and feminist literature alerts us to the process and impact of medicalization in neoliberal

times, suggesting that neuroscience's reliance on experts and evidence as objective truth creates a façade of child-centeredness at the expense of both mothers and children who are marginalized (Campbell, 2017; Buchanan, 2020).

Critical literature suggests that the emergence of research on early brain development constitutes a myth[34] that serves gendered and androcentric agendas (Bruer, 1999; Slee and Shute, 2015). Rather than protecting children by providing better support for mothers, medicalized models divert our attention away from social problems (Leifer, 2001), in this case by placing blame on mothers and constructing them as risks to their children. The individualized concept of mothers' 'failure to protect' their children has been used to justify child welfare responses to substance use and domestic violence, where women who use substances and who live with violent partners are blamed and seen as unfit mothers (see Magen, 1999; Friend et al., 2008; Kaukinen et al., 2016; Boyd, 2019). Literature utilizing qualitative methods has shown that women are often pressured to leave violent relationships, yet they are not provided with resources or supports to do so in a safe way (Alaggia et al., 2007; Johnson and Sullivan, 2008; Hughes and Chau, 2012). In fact, many mothers do not leave because they believe that it would increase the risk of harm for them and their children (Carter et al., 1999). Canadian research shows that mothers are hesitant to leave violent relationships and justifiably so due to a lack of support services and accountability for perpetrators (Alaggia et al., 2007; Hughes and Chau, 2012). When mothers do leave and disclose the violence, their experiences are rarely considered in child custody decisions and although custody may be granted to mothers, "liberal access" is awarded to fathers even if they have been/are abusive (Hughes and Chau, 2012, p. 679).

[34] Bruer (1999) refers to the "myth of the first three years" of life and suggests that there is a destructive nature to holding such an understanding as objective and factual.

While more recent work in Canada has shown mothers discussing positive anecdotes related to support with domestic violence, most often, these women's experiences center around gaps in services and a focus on their "failures as mothers" (Lapierre, 2020, p. 180). Child protection workers are concerned about protecting children from harm, but the focus of their interventions has been shown to fall mostly on mothers, not on fathers despite their recognition that it is the fathers/abusive partners that are the problem (Holt, 2003).[35] While medical models have served to silence women's voices through dynamics of power that promote White, sober, middle-class, heterosexual, and male perspectives, they have also failed to consider children's perspectives (Boyd, 1999; Greene, 2006). Children are often seen as passive and vulnerable beings who, in the context of developmental research, are in a state of becoming rather than one of being (Slee and Shute, 2015). In order to centre children in research and practice and to act in accordance with the *Convention on the Rights of the Child* (OHCHR, 1989), we must ensure their voices are heard (Heary and Guerin, 2006; Gervais, 2011).[36]

When reviewed collectively, various literature lends support to the notion that the state's construction of these mothers as unfit and risky fails to protect children, fails to acknowledge the gendered dimensions of harm and the role of trauma, and fails to hold fathers accountable (Alaggia et al., 2007; Devaney, 2008; Agterberg et al., 2020). Moreover, the impact of social service intervention is disproportionately felt by impoverished and racialized mothers in Canada (Bromwich, 2017; Ritland et al., 2021). While (intersections of) domestic violence, poverty and lifestyles associated with substance use have been shown to impact children in significant ways (Holt et al., 2008; Marcellus et al., 2018), by utilizing an abstinence-based approach based or a

[35] Women often hold a heavier burden as primary caregivers and so they are more likely to be targeted by social services than fathers (Boyd, 1999; Holt, 2003).
[36] Article 12 of the *Convention* specifies that children have the right to express their views freely in ways that will be given due weight in accordance with their age and maturity (OHCHR, 1989).

medicalized model, the current child welfare system does not always protect the best interests of children.

2.5 Harm Elimination and Abstinence

Canada's systems of child welfare and criminal justice have been criticized for being largely punitive and based on abstinence (or harm elimination) models which are supported by neurobiological research that rely on evidence as objective truth (Buchanan, 2020). Despite the intention to protect children from harm, some literature contends that the child welfare system's policies do not support mothers or protect children in many cases (Alaggia et al., 2007; Shlonsky et al., 2007). Abstinence-based models fail to recognize the interconnections and co-occurrence between harm, race, class, sex, victimization/trauma, and other categories of identity that shape experiences of discrimination and inevitably impact experiences for children and mothers (Wolfe et al., 2003; Buchanan, 2020). Abstinence-based models have also been criticized for their lack of trauma awareness and failures in considering the gendered and intersectional aspects of substance and alcohol use (Marcellus et al., 2018; Boyd, 2019).

Traditional forms of treatment typically focus on outright harm elimination, especially for alcohol and substance use which have been constructed as problematic from legal and health standpoints. The medicalization of addiction, or in other words, the disease model has shifted the focus away from the social (i.e., wider economic, and political strains) and towards the individual (i.e., problematic behaviour as a moral failure of the person) (Dollar, 2019). Abstinence from substance use has come to be equated with drug treatment and research on such treatment has been historically based on men (Boyd, 1999; Covington, 2008); moreover, most treatment programs focus on the individual, intentionally isolating clients from their families (Csiernik and Alaggia, 2003). From a social work perspective, abstinence-based approaches for

addiction have evolved as social workers and other professionals recognized their limitations and the strengths of alternative models, like harm reduction (Watkin et al., 2003).

2.6 Harm Reduction

Harm reduction (l'approche de la réduction des méfaits), is an intervention model that meets people 'where they are' and "[les accompagne] en suivant [leur] rythme" (Gauthier et al., 2014, p. 312). This model or "attitude" is a compassionate, non-judgmental, and pragmatic alternative to outright harm elimination (Collins et al., 2011, p. 6). This approach mobilizes trauma-informed care to acknowledge the impacts of trauma, understand how trauma can manifest, and provide care in ways that do not perpetuate further harm or trauma (Covington, 2008; Racine and Madigan, 2019). It is based on principles of safety, trustworthiness and transparency, peer support, empowerment, and consideration of gender and culture (Substance Use and Mental Health Administration, 2014; Ponic et al., 2016). Although harm reduction is a seemingly new and alternative model of intervention for addiction, it has long been used for issues beyond the realm of addiction and encompasses any behaviour that aims to reduce a harmful impact. Today, there are many formal harm reduction programs in the social support realm that target specific risks. Harm reduction is typically associated with substance use (e.g., safe injection sites, methadone titration, opioid replacement therapy); however, this model is also utilized for other 'harms' related to sex work, high-risk behaviours, and domestic violence respectively (see Cusick, 2006; Shlonsky et al., 2007; Collins et al., 2011; Paynter, 2019).

There is a growing evidence base that harm reduction models improve health outcomes for populations that use criminalized substances. Many of these studies are rooted in quantitative methods of content and meta-analyses and systematic reviews and effectiveness of strategies are typically measured with indicators of HIV prevalence, overdose-related mortality, and incidents

of ‘risk’ behaviour (see Ritter and Cameron, 2006; Hathaway and Tousaw, 2008; Kimber et al., 2010; Wild et al., 2017). There is an obvious gap in these types of studies where they fail to consider the qualitative and experiential value of harm reduction on those who are directly involved; moreover, they fail to critically consider the wider contexts for substance use and criminalization of the populations that they study. Qualitative evaluations attempt to fill this gap using interviews and thematic analyses (see Fairbairn et al., 2008; Krüsi et al., 2009; Kilty, 2011; MacNeil and Pauly, 2011; Kilty and Dej, 2012) or a synthesis of qualitative work (see McNeil and Small, 2014).

The majority of the literature on this topic seems to focus on a singular harm, like substance use for example (MacNeil and Pauly, 2010; Bell and Globerman, 2014) and understandably so. As harms are compounded, complexity of research design and analysis increase, but there is an increasing awareness that populations who use substances or who struggle with poverty and homelessness often have concurrent disorders and they live with other difficulties related to violence and trauma (Strehlau et al., 2012; Nathoo et al., 2013).

2.6.1 Harm Reduction and Child Welfare

Harm reduction in the context of the family is sparsely seen in literature, with some exceptions. For example, Haight et al. (2007) interviewed mothers who had experienced significant domestic violence from their partners to determine strategies they used to protect their children from abusive partners. These mothers engaged in harm reduction through various strategies, the most common of which was physically removing or separating their children from situations of violence. Some participants in the sample called a third party or police for help and also developed specific signals with their children as a means of warning them of risk or possible

danger. Longer term strategies were also used to keep children safe, like sending children to live with other family members.

Shlonsky et al. (2007) propose an alternative child welfare model that encompasses harm reduction and evidence-based practice with child protection from domestic violence. The impact of domestic violence on women has been increasingly recognized, but the impact on children is not being recognized at the same pace (p. 353). Although these researchers affirm that harm elimination is the priority, they stress that this option is often not viable for domestic violence relationships. They question to what extent thoughts of idealism, however well-intentioned, lead to harm and missed opportunities. There is a gap in research on harm reduction for domestic violence and it is probably due to difficulty conceding that children are sometimes, in fact quite often, left in harm's way and that placing children in new homes can also lead to harm (p. 357). Although limited research exists, many of these practices are already widespread in the support sector for both child welfare and domestic violence (p. 358).

In addition to domestic violence, existing research supports the effectiveness of integrated programs to support women who are pregnant and parenting while dealing with substance use issues, especially in light of the increasing awareness that harms are often cumulative and co-occurring, and that substance-using women face many barriers in accessing support.[37] Although maternal substance use and other harms are prevalent across all socioeconomic levels, poor and racialized populations are disproportionately affected and they experience greater barriers during pregnancy and with parenting (Marcellus et al., 2015; Rutman et al., 2020). Program integration and harm reduction approaches have received attention for

[37] Recall from section 2.3.1 of this work that substance use is often intertwined with other circumstances related to mental illness, poverty, violence, trauma, criminalization, etc. (Torchalla et al., 2012; Strehlau, 2012; Nathoo et al., 2013; Marcellus et al., 2015; Boyd 2019).

attempting to address these barriers and improve health outcomes so that mothers and their babies have the "best possible start" in life (Nathoo et al., 2016).

Research has shown improved outcomes for both mothers and children through harm reduction, like at the Sheway program in British Columbia where an initiative known as "rooming in" is used to keep mothers who use substances and their babies together after birth for an extended period of time when babies would otherwise be removed and admitted into a neonatal intensive care unit (NICU) (Nathoo et al., 2016). An evaluation of this program found that there was a significant decrease in admissions to the NICU, shorter stays in the NICU, and increased likelihoods of breastfeeding and babies being discharged with their mothers (Abrahams et al., 2010). Statistics from another program in Manitoba, Canada called Manito Ikwe Kagiikwe (The Mothering Project) showed that over the course of the program, a significant proportion of clients stopped or reduced their use, with all of the women having consistent prenatal care after the program (Nathoo et al., 2016).[38] Although these and other harm reduction programs that have emerged in Canada for pregnant persons and their children hold promising evidence regarding their effectiveness, moral discourses often seem to outweigh such evidence (Wild et al., 2017). Such discourses (mis)understand substance use as a form of deviance within an individualized framework, rather than considering the intersections of trauma and oppression on a wider level (Boyd, 1999; Wild et al., 2017; Agterberg et al., 2020; Ritland et al., 2021). As I show next, to better understand the impacts of moral discourses, certain literature explores how frontline workers conceptualize substance use and the subsequent policy implications of their perspectives (see Lee and Zerai, 2010; Benoit et al., 2014).

[38] 49 women participated in the program between April 2013 and September 2014. At the beginning of the program, all of them were using substances, but throughout their participation, 36% stopped using, 47% reduced their use, 39% attended treatment, and 100% had a stable prenatal care team supporting them (Nathoo et al., 2016).

2.7 Frontline Workers' Perceptions

Perceptions of frontline workers are valuable and unique. Through their engagement with marginalized clients, they often perceive patterns and issues in policy, and they may recognize alternative solutions that are not evident to those who do not work with clients firsthand (see Olszowy et al., 2020). Additionally, by exploring their perspectives, we can draw awareness to the stigmatizing and problematic natures of practices and policies based on abstinence. Despite the value of research with frontline workers, there are few studies that explore their perspectives on harm reduction, although there are exceptions. For example, Benoit et al.'s (2014) study points to the ways that service providers conceptualize substance use as inherently problematic based on an individualized and gendered blaming of women. Although the providers work in a harm reduction program, they are impacted by a wider abstinence-based and neoliberal rhetoric. Lee and Zerai's (2010) study points to a reconceptualization of success (away from abstinence) as potentially leading to more positive outcomes, but this suggestion arises from the providers' client-centered practices that are distanced from traditional notions of success. Both studies interview frontline workers in harm reduction programs; however, the findings differ with regards to frontline workers' perspectives. More exploration is needed on their conceptualizations and opinions of harm reduction. This project attempts to address the significant gap in research on harm reduction in which frontline support and social workers have not been consulted, taking Marcellus et al.'s (2015) suggestion that more research is needed on how providers view success in programs using harm reduction for women and their children.

2.8 Chapter Summary

This chapter has presented a review of various sets of literature related to the duality of motherhood as both a powerful possibility and a co-opted institution, to the construction of

motherhood in neoliberal times, and to the tensions between motherhood and intersectional identities that are constructed as risky. The (in)compatibility of children's rights and mothers' interests was also explored through the literature as it exists in both an abstinence-based child welfare system and an alternative model of harm reduction. The following chapter presents the theoretical framework from which the data is analyzed (Chapter 3).

3. Theoretical Framework

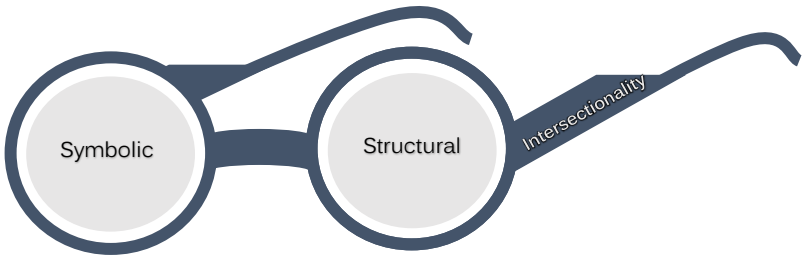
In order to analyze the interview data[39], this research draws upon multiple conceptual lenses to mobilize a theoretical framework that accounts for intersectional stigma both on symbolic/interactional and structural levels to present a holistic and critical analysis of frontline workers' perspectives. This study's theoretical framework exists within a constructionist paradigm that views reality as a social construction based on the interactions and perceptions of social actors (Goffi, 2016)—it is also informed by feminist perspectives and methodologies. While the theoretical framework related to intersectional stigma is applied mainly to mothers in this study, particularly since the interview participants support mothers primarily, it must be noted that it also applies to children and their rights, as do all other dimensions related to marginalization and discrimination.

Though I seem to engage less with a children's rights' perspective in my analysis, I contend that there is much common ground or compatibility between the interests of mothers and children. Literature also suggests that we can theorize children's rights through a feminist lens (see Minow, 1986). By engaging with a feminist perspective and prioritizing mothers' wellbeing through harm reduction, there is an underlying intention to better protect children's rights, which becomes evident in the following analytical chapters (Chapters 5-7).

The figure on the following page (Figure 4.1) provides a visual depiction of the theoretical framework or the 'glasses' used to view the data in the project:

[39] The interviews are referred to as data for clarity's sake; however, it is important to acknowledge the qualitative and human nature of the insights shared by the interview participants. It is not this researcher's intention to minimize their experiences by referring to them purely as data in the service of this research.

Figure 1. *Visualizing Intersectional Stigma Lenses*



The 'glasses' through which we will view the perspectives of the participants interviewed for this study are made up of intersectional stigma lenses, which include aspects of Goffman's micro-level (symbolic/interactional) stigma (e.g., the left lens in Figure 1)—and Foucault's macro-level (structural) stigma (e.g., the right lens in Figure 1). Intersectionality is represented as the temples or arms of the glasses because it is a necessary element that allows our theoretical glasses to remain on our heads—it informs our understanding of (intersectional) stigma.

This project takes inspiration from previous work that has theorized experiences through the lens of intersectional[40] stigma in carceral and public health settings (Bowleg, 2012; Quinn et al., 2019; Kilty, 2021) and applies it in a new context to understand the stigmatization of marginalized mothers by the child welfare system. Although a stigma action framework[41] has been applied in previous research to examine barriers to harm reduction and child welfare services for pregnant women and mothers using substances (see Wolfson et al., 2021), this research presents an expanded focus by considering the role of intersectionality in shaping

[40] I argue that I am bringing forth a feminist-informed view of intersectionality, like Zufferey and Buchanan (2020) have done in their recent work. Feminism allows for a gendered perspective, but also an expansion beyond gender to consider other identities that are intertwined with gender and oppression. It has encouraged and inspired me to apply the same inclusive views (and accordingly, allows us to shed light on exclusion) to other identity markers that we apply to gender.

[41] Wolfson et al. (2021) analyzed data using a framework developed by Canada's Chief Public Health Officer where stigma is conceptualized as a barrier experienced at individual, interpersonal, institutional, and population levels. The Framework available here: https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-action-framework-infographic.html.

experiences of stigma as a barrier. Similarly, while recent work has considered intersectionality from a feminist perspective related to motherhood (see Lapierre, 2020; Moulding, 2020; Zufferey and Buchanan, 2020), a framework that considers the role of stigma more fully has been seemingly absent. By bridging intersectionality and stigma, this project explores how multiple social identities related to motherhood/pregnancy, substance use, and violent domestic partnerships impact the experience of stigmatization and discrimination.

In this chapter, I begin by exploring the interconnection between multiple criminological streams in relation to stigma to situate this study's theoretical foundations (section 3.1). While this project draws upon constructionist and feminist schools of thought to illuminate the punitive and discriminatory aspects of the child welfare system that lead to stigma, there are ways that symbolic interactionism and critical criminology also inform my analysis. In section 3.1.1, I briefly note this study's contribution to the multidisciplinary field of gender and critical drug studies, which leads into a discussion of intersectional(ity and) stigma in section 3.2. Section 3.2 presents stigma as both symbol (3.2.2) and structure (3.2.3). Considering both the micro-level (symbolic) and macro-level (structural) aspects of stigma allows for a more holistic analysis of the interviews.

3.1 Interplay Between Interactionist, Constructionist, Feminist, and Critical Schools[42]

Several schools of criminological thought emerged throughout the late-20th century, each of which attempted to respond to the limitations of classical and positivist streams. Symbolic interactionism, feminism, constructionism, and critical schools of thought have all alerted us to the flaws of the punitive and deterministic perspectives inherent in classical and positivist criminology, albeit in different ways as I describe below. While this study's foundations are constructionist in nature, I utilize feminist methodologies and acknowledge the interconnection of symbolic interactionism and critical criminology that inform the theories that I am mobilizing. Criminological literature often references these terms (symbolic interactionism, feminism, social constructionism, critical criminology), but it is important to note that their meanings are influenced by the intention of their users (Schwandt, 1998). In other words, they are constructed in specific ways and although there may appear to be consensus[43] in the social sciences about their conceptual meanings, assuming consistency across language would be to ignore the dynamic, complex, and contested nature of knowledge, thus representing a departure from the constructionist paradigm in which I situate this work. It is necessary to explicate the meaning of each perspective based on academic literature to underscore their relevance to this study's theoretical underpinnings.

[42] While I largely note the compatibilities between these four schools of thought (symbolic interactionism, constructionism, feminism, and critical theory), I also recognize their incompatibilities, especially as they relate to epistemological foundations and beliefs. For example, while constructionists view knowledge as a construction based on consensus that can be seen to accumulate over time, critical theorists locate knowledge in specific sociohistoric contexts that change, thus suggesting that knowledge also transforms as time passes (Guba and Lincoln, 2004). Moreover, while interactionism focuses on a continuous process of interpretation at a micro-level, critical theory revolves around the dynamics of social change at a macro-level (Caputo and Hatt, 1996). It is necessary to explore the underlying beliefs of each paradigm, as these inform the nature of research and research goals, and while there are complimentary aspects, their differences are also acknowledged.

[43] Some researchers problematize language in social science, cautioning us to "beware of words" as Bourdieu says (in conversation with Wacquant, 1989, p. 54), because of the limitations that come with using language in orthodox ways (i.e., in alignment with the perceived 'general consensus') without exploring its meaning, but more importantly, its nature and accordingly, the inherent (im)possibilities it provides (see Wacquant, 1989; Blaikie, 2000; Alvesson, 2002).

Symbolic interactionism belongs to an interpretivist tradition that views identity (i.e., the self) as being continuously shaped by social processes, which in turn, shape behaviour based on the meanings that social actors create (Mead, 1934). According to labelling theorists, identities are influenced by the ways in which society categorizes or labels people as offenders—in this sense, our interpretation of meaning through our interactions with others (including stigmatizing interactions resulting from labelling) form the foundations for social control (Maddan and Marshall, 2009; Tibbetts, 2018). Symbolic interactionism and constructionism both focus on how meaning is created and interpreted by social actors, but constructionism can arguably be seen as also having a wider (macro-level) focus compared to symbolic interactionism, which tends to have a micro-level focus (Leeds-Hurwitz, 2006).

While micro-level interpersonal interactions are considered in this study as they relate to stigma, they are conceptualized as symbolic of the wider structural stigmatization at play. While symbolic interactionism's focus on the interplay between interactions and structures help to inform part of a theory mobilized in the study, namely stigma, Kilty and Crépault (2016) note that symbolic interactionism does not necessarily have advocacy as its goal. They suggest that feminism can help to fill in these gaps. Comack (2006) refers to the "feminist engagement with criminology" (p. 12) as stemming from an awareness that women constituted an afterthought in criminology and beyond (p. 12). Feminist criminologists attempted to overcome and even exceed the bounds of traditional criminology's exclusion of women's voices; in addition, we begin to see an increasing acknowledgment of positionality in feminist research that considers intersections of multiple identities including and beyond gender (Kilty, 2014).

Zuffery and Buchanan (2020) suggest that an intersectional feminist approach can be useful in research, policy, and practice related to women, mothering, and the family. They also

explain that acknowledging the aspects of gender, class, race, poverty, sexual orientation, and mothering are vital in understanding and theorizing women's experiences of discrimination. Together, the complimentary elements of symbolic interactionism and feminism give visibility to gendered and intersectional experiences of stigmatization and discrimination based on notions of difference, but I also consider the interconnection and relevance of critical criminology in feminist and constructionist thought.

Critical criminology aims to question legal definitions of crime through a reconceptualization of political and economic systems as mechanisms of exploitation (Cohen, 1988). Both symbolic interactionism and critical criminology recognize the role of power diachronically, that is over time, but in different ways. Symbolic interactionism analyzes the interactional role of power and how it has led to labelling certain individuals as 'criminals' (Caputo and Hatt, 1996). Conversely, by drawing attention to 'crime' as a product of (people and systems of) power, critical criminology explores the changing dynamics of criminality and criminal justice to render visible their oppressive nature (Caputo and Hatt, 1996). Critical thought allows for a theoretical illumination of resistance to oppression which can be mobilized to create change through research—as Guba and Lincoln (2004) note, such change (or "transformation") through critique is the aim of critical inquiry (p. 30).[44] Herein lies the clear connection between critical criminology and feminism when we consider that politics (i.e., politicizing issues through deliberate action) and praxis (i.e., working with a goal of creating social change) are essential elements of feminist research (Kilty, 2014, p. 127).[45]

[44] This study did not mobilize resistance as a theoretical concept given its limited scope; however, future work should explore clients' and frontline workers' respective demonstrations of agency and examine whether they constitute forms of resistance. As noted here, this exploration is important when we consider that theoretical illuminations of resistance can be mobilized though research to create change.

[45] Kilty (2014) outlines "the three P's" of feminist research as positionality, politics, and praxis (p. 127). Positionality is discussed in the next chapter as it relates to feminist methodologies (see section 4.2.1).

Constructionism also holds advocacy and activism as essential to its goals in research, yet it emphasizes the researcher's role as an active participant who shapes or 'constructs' research findings. While certain elements of critical criminology are evident in this study's critique of structural systems that perpetuate harm in discriminatory ways, they are understood within a paradigm that views the researcher as a "passionate participant" rather than a "transformative intellectual" (Guba and Lincoln, 2004, p. 34).[46] Constructionism aligns with my own beliefs about the nature of social science research, and they shape the analysis and subsequent findings of the study, so while this project exists within a constructionist and feminist paradigm, I recognize the interconnections and relevance of symbolic interactionism and critical schools of thought, both of which inform the theoretical concept of stigma.

3.1.1 A Note on Gender and Critical Drug Studies

Since this study is concerned with harm reduction and substance use in a gendered context, its findings contribute to the multidisciplinary field of gender and critical drug studies. Critical drug studies comprise a vast array of disciplines and methodologies to explore the racial aspects of drugs and crime, as do gender studies. Campbell and Herzberg (2017) invite us to begin—or in the case of some authors[47], continue—to incorporate gender into the increasingly expanding area of critical drug studies.

One area of engagement of gender and critical drug research relates to substance use during pregnancy and parenthood. As Boyd (2019) explains, past work that falls within this narrower focus alerts us to the ways in which the regulation of women intersects with the

[46] I discuss my role as a participant and how I view the research participants as partners in research in the following chapter (see section 4.2.1).
[47] Scholarship already exists in the realm of gender and critical drug studies (see Rosenbaum, 1981; Boyd, 1999).

regulation of substance use and mothering (p. 110); in her earlier work, she clearly and effectively articulates such a point on these intersections:

> [W]omen's experience of illicit drug use is mediated by their race, class, and gender in conjunction with the legal and socio-economic environment.
>
> -Susan Boyd[48]

The excerpt above is fitting for the research matter in this project and it serves as a foundation for a theoretical position grounded in intersectionality. The following section contextualizes intersectionality as a theoretical concept to justify its expanded use beyond considerations of race, gender, and class alone—again, intersections of identity are the temples or arms of our theoretical lenses (see Figure 1).

3.2 Intersectional(ity and) Stigma

Crenshaw's (1989) explication of intersectionality conceptualizes experience as the relation between race and sex as they exist and intersect with and through one another. Various academic works utilizing an intersectional understanding expands on Crenshaw's theory. This project aims to follow in the footsteps of literature that mobilizes intersectionality as a necessary "staple" (Bowleg, 2012, p. 1267) that allows us to explore and represent differences in experience based on intersections of gender, race, class, sexual preference, citizenship status, (dis)ability, health, geographic location, religion, addiction, and criminalization (e.g., McDonald, 1997; Smye et al., 2011; Taylor, 2011; Kilty and Dej, 2012; Meyer, 2012; Parson et al., 2016; van der Heijden et al., 2019). While identity categories related to gender, race, and class are considered in this work, there is a theoretical expansion that aims to consider pregnancy,

[48] The quoted content is an excerpt from Boyd (1999), p. 36.

motherhood, substance and/or alcohol use, and violent domestic partnership as they intersect with the child welfare system to culminate in unique experiences of stigma.

Recent work has considered normative constructions of motherhood using an explicitly intersectional feminist approach (see edited works in Zufferey and Buchanan, 2020). I attempt to draw upon, but also expand on such literature by framing intersectionality within a feminist lens where it is stigma that renders visible various intersectional experiences. Such an expansion is evident in previous research that has utilized the theory of intersectional stigma to better understand experiences (see Bowleg, 2012; Quinn et al., 2019; Kilty, 2021). Kilty (2021) conceptualizes intersectional stigma as a prism, explaining that each area of identity can be understood as a point where a particular stigma may be refracted (p. 1034). Multiple identities play off one another (or intersect) to create a layering effect whereby the experience of stigma, and thus the experiences of marginalization and discrimination, are aggravated (p. 1034). Throughout the analysis, intersectionality conceptually enables a deeper understanding of stigma and accordingly, of the mechanisms through which discrimination occurs.

The following subsection explains the significance of using a holistic theoretical lens that allows us to highlight experiences of intersectional stigma at an interactional (micro) level, which reflect or symbolize interlocking systems of privilege and oppression at a structural (macro) level (Bowleg, 2012, p. 1267)—recall that symbolic and structural stigma make up the left and right respective lenses of our theoretical glasses (see Figure 1).

3.2.1 "A More Holistic Picture" of Stigma[49]

> One needs to stand between [Foucault and Goffman] in order to take advantage of both. There is a clear sense in which Foucault's research was 'top-down', directed at entire 'systems of thought' […]. Goffman's research was 'bottom-up' – always concerned with individuals in specific locations entering into or declining social relations with other people.
>
> -Ian Hacking[50]

The quote above draws attention to the dialectic of agency and structure in theorizing stigma. By combining the work of Foucault and Goffman, Hacking (2004) suggests that we can reconcile their respective limitations. Where Goffman focuses on micro-level interactions, Foucault focuses on the origins of power and the production of knowledge, since the former creates and constrains the latter. Expanding on Hacking's (2004) earlier work, Hannem (2012) theorizes structural and symbolic stigma from a sociological perspective and suggests that artfully combining Foucault and Goffman's theories can create a "more holistic picture" that serves an activist political agenda concerned with people's lived realities (pp. 11-12).[51]

Foucault's contributions are significant in criminological and sociological fields given that the origins of power matter when disempowerment based on intersecting attributes are built into structures and institutions. While Goffman ignores the role of power on a larger scale, he allows us to explore individual experiences of stigma that Foucault negates so we can question how interactions maintain stigma at a symbolic level.

[49] The quoted content is an excerpt from Hannem (2012), p. 11, which is discussed in the paragraph that follows.
[50] The quoted content is an excerpt from Hacking (2004), pp. 277-278.
[51] Hannem acknowledges the constructionist roots of her work on stigma (see Bruckert and Hannem, 2012, p. 2), which align well with this project's constructionist underpinnings—such foundations in social constructionism consider both micro and macro-level understandings (Cruickshank, 2011).

3.2.2 Goffman and Symbolic Stigma: The Plights of the Discredited and the Discreditable[52]

Within a social constructionist view of reality, interactions between individuals lead us to create shared beliefs and meaning; society establishes norms and expectations of its members depending on previously established categories (based on occupation, for example) (Goffman, 1963, p. 10). Our perceptions impact the ways that we shape our realities, as well as how we define our own identities and the identities of others. Within this paradigm, Goffman (1963) begins to conceptualize stigma as an attribute that is "deeply discrediting" in that it makes someone different from others in ways that are seen as less desirable or outside of the bounds of normalcy (p. 10). Such an attribute constitutes a "discrepancy between the virtual and actual social identity," although stigma as a concept is not fully conceptualized solely as an attribute (p. 11). It is meant to encompass relationships and more specifically, the relationship between attribute and stereotype[53] which tends to culminate in discriminatory behaviour (p. 59). As Hannem (2012) explains, discrimination serves as our observable evidence of stigma (p. 5).

Marks of criminality, otherness, and deviance as they exist based on physical attributes and stereotypes lead someone to be easily and immediately *discredited* based on racialization or mental illness for example. In other cases, though, the attribute may not be easily observed, wherein the subject in question becomes *discreditable* according to Goffman. Their plights differ: on one hand, the *discredited* manages tensions during interactions, while the *discreditable* must manage information related to their perceived "failing" (Goffman, 1963, p. 50). The management of identity based on aspects of the *discredited* and the *discreditable* are an

[52] Erving Goffman (1963) references the "plight of the discredited" and "that of the discreditable" in his seminal work, *Stigma: Notes on the Management of Spoiled Identity*, first on page 12 and later on in the second chapter and throughout the remainder of the book.

[53] Stereotypes are said by Goffman (1963) to be a kind of "profiling of normative expectations regarding conduct and character" (p. 11). In other words, they constitute mainstream definitions of normal and abnormal characteristics and the value that these characteristics are assigned.

important element of identity management and relationship dynamics. A power imbalance is created in both situations whereby the person in question is either already seen as 'Other' or in the latter case, they become fearful and internalize feelings of shame due to their acute awareness that others could react negatively to them if element(s) of their difference were to be revealed.

The clients that the frontline workers/interview participants in this research support may often be seen as discredited because of the apparent marks of their substance use or victimization as they intersect with marks of racialization at times—these stigmatic symbols cause them to be discredited and thus discriminated against as they are seen as bad mothers or mothers-to-be. Using Goffman's theory, we can simultaneously theorize that marks of substance or alcohol use and victimization, as well as criminality, can often remain unseen, yet the fear and shame of their secrecy brings about a discreditable status to the subjects.

While Goffman alerts us to the symbolic aspects of stigma in interactions and identity management which are valuable in exploring and understanding lived experiences, his theory sheds less light on how or why stigma comes about or, in other words, why we see certain attributes as normal and others as deviant and how these views have been shaped in terms of social structures and systems of power. To fill in these gaps, we turn to Michel Foucault's theories on power.

3.2.3 Foucault and Structural Stigma

Hannem (2012) explains that symbolic stigma is largely a psychological concern. Only does it leave the realm of the personal and become pertinent in sociology when agencies and institutions stigmatize certain groups of individuals. In the context of this project, the agencies that make up the child welfare and criminal justice systems in Canada can arguably be seen to both systematically and systemically discriminate against mothers who do not meet normative

standards of sobriety and Whiteness through moral regulation (Boyd, 2019).[54] From a macro-level social constructionist perspective, we must consider the role of knowledge and power.[55] By examining the historical dynamics of power which are inextricably linked to knowledge/knowledge production, Foucault (1980) suggests that we can trace back the roots of the normalization process to better understand how it (along with other techniques of power like medicalization and surveillance) functions. A standard of normalcy implies the existence of an "inspecting gaze" upon individuals—a gaze that they may eventually begin to internalize (Foucault, 1980, p. 155).

In interviews with former female prisoners, Kilty and Dej (2012) found that the women engaged in this kind of self-inspection/surveillance process as a means of negotiating their own identities in relation to their conceptualizations of 'good' mothers (see Kilty and Dej, 2012). The 'bad' mother, that is the mother who uses substances, the mother who is criminalized, the mother who is not completely devoted to her child(ren) in the ways that intensive mothering requires…this mother is a risk to her offspring in the eyes of the child welfare system (Veenstra and Keenan, 2017).[56]

Hannem's definition of structural stigma based on Foucault's theories will be used in this project's theoretical framework and is as follows:

[54] Since the study explores the experiences of mothers in a Canadian context through the perspectives of frontline support workers, the study is limited insofar as it does not directly consult mothers and children about their own experiences. Additionally, given that the research only considers a Canadian context, work that examines these issues in an international comparative context would be helpful in gaining a deeper understanding.
[55] Macro-level social constructionism has been largely influenced by the work of Foucault (Cruickshank, 2011).
[56] Refer back to section 2.2.2 of this work for a more detailed review of the literature related to ideal mothering and its history in the context of this project. For a more detailed discussion on the regulation of motherhood in a Canadian context, see Miller et al. (2017).

> […] structural stigma arises out of an *awareness* of the problematic attributes of a particular group of people and is based on an intent to manage a population that is perceived, on the basis of the stigmatic attribute, to be "risky" or morally bereft.
>
> -Stacey Hannem[57]

She goes on to explain that the group of people in question need not experience stigma on a symbolic level in their interactions for it to exist. They are 'marked' regardless because they belong to a group that is "risky" and are therefore likely to be targeted for various interventions and modes of surveillance (p. 24). Structural stigma can be seen to manifest through risk labels and assessments that serve to regulate motherhood and pregnancy. When a mother is constructed as a risk by the child welfare system, they are targeted for intervention; moreover, when this targeting is based on discriminatory constructions of risk, we have evidence of structural stigma. Examining the medicalization of motherhood, which has the construction and subsequent assessment of risk at its core, allows us to illuminate the harmful and disproportionate impacts of structural stigma on mothers and their children.[58]

Medicalization and the Risk with Risk Construction/Management. Risk is an integral component of the medical model of mothering where we see women who use illegal substances being labelled as high-risk and subsequently flagged by child welfare systems (Boyd, 1999; Bromwich, 2017); moreover, risk labels that emerge from this standpoint are assumed to be objective despite their socially constructed nature. The lens of medicalization illuminates the dynamics of risk assessment in the formal medical system and how they lead to child apprehensions and parental isolation (Campbell, 2017). Rather than providing better support for mothers who use substances, constructions of risk serve to create power imbalances between care

[57] The quoted content is an excerpt from Hannem (2012), p. 24.

[58] See section 7.1.2 (The context of motherhood: Children's Services' involvement) for a discussion of birth alerts, which represent an example of discrimination stemming from structural stigma.

providers and mothers while reinforcing structural stigma (Campbell, 2017). This stigma disproportionately impacts impoverished and racialized women who "bear the brunt of punitive drug policies" (Boyd, 2019).

Those who are constructed as risky and 'bad' mothers exist in direct opposition to 'good' or 'normal' mothers (Veenstra and Keenan, 2017) and a theoretical lens that mobilizes structural stigma allows us to see how those labels are inextricably linked to dynamics of privilege and oppression. Such a theoretical analysis will enable a deeper understanding of the interview participants' discussions of their clients' experiences of barriers related to stigma and discrimination.

3.3 Chapter Summary

In this chapter, I have presented the theoretical lenses of intersectional stigma both symbolic/interactional and structural that make up this project's theoretical framework. While this study is situated mainly within a constructionist and feminist paradigm, I recognize that symbolic interactionism and critical criminology inform the theoretical framework and contribute to my understanding of gendered and intersectional experiences of stigma and discrimination. Additionally, although there is a feminist focus on mothers' experiences of intersectional stigma, this theoretical framework allows for an understanding of the indirect consequences of stigma for children, whose rights and lives are ultimately and significantly impacted by discriminatory policies and practices faced by their mothers.

By employing an intersectional analysis to explore frontline workers' perspectives on how best interests are balanced for both mothers and children in harm reduction programs and more specifically, in the wider child welfare system where these programs are bound, this study contributes to interdisciplinary gender and critical drug studies' literature on the criminalization

of substance use and the regulation of motherhood.[59] The intersections of categories related to pregnancy, motherhood, substance use, and violence necessitate significant consideration, as they impact stigmatization and thus, the outcomes for both mothers and their children.

Goffman's (1963) theory of symbolic stigma allows me to explore the implications of stigma on interactions between individuals. Since Goffman's micro-level theoretical lens sheds less light on structural dimensions, I utilize Foucault's theories to account for structural aspects of stigma which consider institutionally embedded constructions of risk in the context of disempowerment, as Hacking (2004) and Hannem (2012) suggest. The following chapter provides a more detailed discussion of the methodology that guides the research analysis.

[59] The word 'bound' is used purposefully here to denote the significant impact that the child welfare system has in determining outcomes for mothers and their children regardless of the harm reduction programs that those mothers participate in and regardless of research that supports the positive financial and human impacts for those who use substances (Ritter and Cameron, 2006; Hathaway and Tousaw, 2008) and more specifically, for substance users who are pregnant or mothering (Nathoo et al., 2013).

4. Methodology

This chapter provides a detailed description of the methods used to carry out this research—methods that I place within a constructionist paradigm guided by feminist methodologies. I begin by detailing the research purpose in section 4.1 before locating this project epistemologically in section 4.2. Technical elements of the study related to research methods and data collection are discussed in section 4.3, followed by a detailed description of data analysis in section 4.4 and project limitations in section 4.5.

4.1 Research Purpose

During my experience with frontline work[60], I was inspired by those around me who worked tirelessly for their clients despite the limitations of the systems that they were navigating both with and on behalf of their clients. Based on my own observations and on previous research (see Lee and Zerai, 2010; Benoit et al., 2014), it became apparent that through their engagement with society's most vulnerable, frontline workers often perceive patterns, issues, and develop pragmatic solutions that are not evident to those who do not work with clients firsthand. Thus, by interviewing frontline workers who directly support clients and listen to their overall experiences, we can gain a greater understanding of the intersection between mothers' needs and the rights of their children. While such an understanding is gleaned from the perceptions of frontline workers and not from mothers or children themselves, which constitutes a limitation of this study[61], their insights related to challenges and successes in their own work can inform best practices in support sectors that aim to secure rights for both women and children. Additionally,

[60] I worked and volunteered in the social work and non-profit sectors during my undergraduate degree where I supported a variety of clients, including women, children, and men, who were involved with the criminal justice and child welfare systems. I also worked for two years in private security where I often interacted with vulnerable populations who would seek shelter in the parkades that I was meant to patrol and survey.
[61] This limitation is discussed in section 4.5.

in the context of limited research that exists on the dyad between the rights of women and those of their children in harm reduction approaches, this project represents a starting point from which future qualitative research in this realm can be built.

The purpose of this research has been largely influenced by my own position, which is shaped by my life experiences and the experiences of those close to me. The connections I have to this research are both personal and professional and I reflect on them throughout this study as they impact my own interpretations and guide me towards the goal of increased understanding. By engaging in reflexive research, I recognize that emotion is embedded in the purpose of this project; moreover, if we conceptualize research as emotion work as Hannem (2014) does, then as a researcher, I must be prepared to recognize the role of emotion in the development of knowledge (p. 280). An additional consideration related to positionality includes the points of difficulty and those of privilege that I hold, which shape my interpretation of this work; indeed, it is a privilege to be able to conduct this research to begin with. While these positional aspects may constitute potential biases in interpretation, by recognizing them and engaging in reflexive research, I attempt to limit their threat to validity throughout the research process in an ethical way (Felices-Luna et al., 2014).[62]

4.2 Epistemology and Ontology

There are different intellectual traditions that underpin both quantitative and qualitative research. There is a tendency to make the discussion about these approaches a technical one despite the importance of analytical and ethical implications; additionally, quantitative

[62] While reflexivity was part of this research process, due to privacy reasons, I refrain from explicating specific aspects of it throughout the work . While I acknowledge this omission, I demonstrate my accountability in listing the basic steps I followed to practice reflexivity in section 4.4 (Analysis strategy). As I continue to conduct research in the future, I am constantly navigating my own relationship with the topics at hand and their connections to those around me.

approaches are often thought to be more legitimate with regards to validity and reliability, but interpretation still occurs in 'strictly' quantitative approaches (Silverman, 2005). Focusing solely on technical aspects distracts researchers from significant issues that exist regardless of whether the researcher is aware or not. Bryman (1992) illustrates this caricaturized understanding of research approaches—an understanding that is particularly problematic when the words themselves denote far more than just methods for gathering empirical material. By moving beyond a technical understanding, we can recognize differences and limitations in intellectual traditions that guide our research, whether we are aware of it or not. I focus on the aforementioned analytical and ethical implications of this project in this section, first by locating this study's methods within broader feminist and constructionist methodologies which are underpinned by a critical realist philosophy that characterizes my ontological assumptions.

Empirical material is often seen as a legitimate way to represent our object of study—it is our connection to the material world. Alvesson and Karreman (2011) problematize this empirical material or data, as these things we 'collect' are more realistically our own constructions that imply certain embedded assumption about the way we see the world and research (p. 29). Since we all have very different experiences and assumptions, our formations and interpretations in research are inevitably very different; but as many social scientists acknowledge, there is inherent value in diverse understandings in research.

When we interview people, we are interpreting their constructions of the social world and this requires reflexivity and a deeper understanding of our own beliefs and positionalities (Alvesson and Karreman, 2011). There is a tendency—a somewhat ironic one among those who attempt to assign and create meaning—to view social science language as being consistent across the discipline. For example, Blaikie (2000) says induction requires a view of one objective

reality to generate a new theory, whereas Tavory and Timmerman (2014) explain that induction's strength is not in generating new theory. This example of discrepancy points to the importance of conceptualization in research design, not just of the phenomena to be studied, but of the underlying assumptions of the researcher and therefore, the research itself. In discussing the production strategy, I explicate my own definition of the constructionist paradigm in which I find myself working based on my own understanding of the world. Being aware of this paradigm allows for greater reflexivity and awareness of choices and possibilities in my own research.

4.2.1 Constructionist and Feminist Methodologies

The constructionist paradigm can be conceptualized as having elements of both postpositivism's ontology and interpretivism's epistemology (Levers, 2013). Like postpositivism, constructionism utilizes a critical realist ontology that denotes the need for rigour, precision, and logical reasoning when studying things that transcend purely physical observations and the use of a subjectivist epistemology (Levers, 2013). Like interpretivism (where we place the symbolic interactionist tradition), constructionism is characterized by a subjectivist epistemology where meaning is created based on our interactions and our interpretation of those interactions (Bryman, 1992; Schwandt, 1998). Unlike symbolic interactionism though, constructionism does not aim to mainly recognize subjective human experiences and actions; rather, its goal is to draw attention to the constructed nature of knowledge to better understand it (Guba and Lincoln, 2004). Within this tradition, the nature of reality can be seen to exist independently from what can be observed. It is our perceptions, theories, and constructions that guide our own constructions of subjective realities. Social science practice attempts to develop agreements over descriptions of phenomena, though this knowledge is constructed rather than discovered in a constructionist view (Levers, 2013).

Interviews are one way that we can explore these different subjective realities through an inductive mode of reasoning, although Blaikie (2000) warns us of the assumption that these observations can produce objective data that represent a mirrored reality. From a constructionist perspective, interview data is not a direct connection to one shared world; rather, the interview allows us to bring to the surface many nuanced understandings of people's experiences, which Mander (2010) suggests is a powerful and necessary exercise. Despite criticisms and an increasing awareness of the complexity of interviews[63], interview methods that utilize individual testimonies are powerful as they reveal "hidden connections [and] spheres of experience" (Mander, 2010, p. 264).

By utilizing feminist methodologies that rely on interviews and conducting research "by, for, and with women" (Kilty, 2014, p. 139), we are able to listen to women's voices as we embrace a dialectical method of inquiry that acknowledges the complicated dynamics at play in everyday experiences (Acker et al., 1991; Boyd, 1999). These types of research practices can lead to policy changes and draw awareness to resistance while also facilitating spaces of resistance (Kilty et al., 2014). In conducting this research via a feminist methodology, I have attempted to demonstrate an awareness of positionality[64] by moving away from Eurocentric methodological approaches in two ways: first, by acknowledging what characterizes such

[63] Alvesson and Karreman (2011) explain that there has been increasing awareness of the complexity of interviews. They identify eight central problems that exist for an interviewee during an interview related to social, cognitive, institutional, motivational, and other challenges that interviewees must solve during these exchanges (pp. 5-6).
[64] Kilty (2014) outlines "the three P's" of feminist research as positionality, politics, and praxis (p. 127). Positionality recognizes women's differences and the figurative locations of their respective oppressions.

approaches, and second, by explaining how I utilize my own subjectivities as a way of resisting Eurocentrism.[65]

Questioning Objectivity. Collins (1998) explains that the "Eurocentric, masculinist knowledge validation process" requires researchers who distance themselves from the "object" of study through an "absence of emotions" in that research (p. 205). She leads us towards an alternative Afrocentric feminist epistemology that acknowledges the importance of lived experience, dialogue, and an ethic of care (Collins, 1998). Mander's (2010) work, which is centered around human rights and empathy, echoes themes of engagement, care, and personal accountability to research subjects, which are important elements in research that move "beyond statistics" to democratize knowledge (p. 269). Taking inspiration from Collins (1998, 2009) and Mander (2010), I problematize the concept and operation of objectivity by rejecting the embedded assumption that empathy and personal engagement compromise the validity of social research. Although interviews have many perceived limitations, this kind of engaged research holds powerful potential for understanding nuanced experiences, particularly if they are conducted with empathy and respect (Mander, 2010).

As a researcher, I viewed myself as a participant in the study while simultaneously seeing the interviewees as both participants and partners in the research. Within a constructionist paradigm, I view myself as a "passionate participant" because of the influence that my constructions have on the findings in this study, although I tried to minimize that influence by collaborating with the participants so that their perspectives would be as fully represented as

[65] I recognize that I am a White woman of European descent and that this fact, in combination with my training and experience as a social science researcher, cannot be separated from my work despite the efforts that I am making to do so. My hope is to demonstrate and continually participate in reflexive practice by taking the suggestions of Collins (1998; 2009) and Mander (2010) who seek to promote alternative methodologies that are more Afrocentric and empathy-based.

possible.[66] Positioning myself as a passionate participant represents an attempt to draw awareness to my own influence on the research while simultaneously equalizing the dynamics of power between myself and the interviewees. Rather than viewing myself as a "transformative intellectual," which Guba and Lincoln (2004) explain is the researcher's role within a critical paradigm (p. 34), as a constructionist and feminist researcher, I hold a dual recognition of the constructive nature of research and the importance of elevating interviewee voices.

As I was creating the interview guide, I informally discussed the topics with contacts in the field to ensure that I was engaging with material that frontline workers would view as relevant.[67] Additionally, I made sure to check in with the interviewees about whether the questions in the interview guide were appropriate and relevant throughout[68] the interview process. I strived to create an environment of mutual understanding and respect with potential and confirmed participants. I shared with the participants that this research was conceived because of my time in frontline work and the deep respect that I have for support workers, many of whom enter this field because of their own experiences and subsequent inclinations to support those who are often pushed to the margins. My own time in frontline work was inspired for those very reasons and I wanted to allow the participants to share their insights after I had learned so much from frontline workers about compassion, tenacity, and everyday best practices.

Rather than try to distance myself from the research matter and the difficult moments in the interviews, I often felt myself becoming more entangled with them as I engaged with my

[66] I recognize my influence on the findings related to both the data collection (interview) and the subsequent analysis. Such limitations are discussed in section 4.5. I attempted to minimize that influence by checking in with interview participants throughout the research process—see further down in this paragraph.
[67] When I engaged with contacts in the field prior to ethics approval, I did not attempt to recruit participants for the study, but rather, consulted on various topics and the relevance of certain questions.
[68] Due to ethics regulations, I did not consult the interviewees on the interview guide prior to Research Ethics Board (REB) approval. After the interviews, the participants remarked that the questions were relevant to explore and draw awareness to.

own responses and reflected on them during the analysis process. While such entanglement or reflexive engagement warrants significant consideration, it is quite often seen as a limitation despite the notion that research does not rely on the exclusion of emotions—in fact, emotions are a key part of the human experience (Hannem, 2014). Within constructionism, it is necessary to recognize that human experience shapes processes of (re)construction.

4.3 Methods

This research was conducted in a large urban centre[69] in Alberta that has various harm reduction programs for mothers and pregnant persons and thus, many frontline workers who interact with and support clients utilizing these strategies. The region was selected based on my familiarity with programs and access to research participants, but also due to the opioid crisis in the province and its evolving relationship with harm reduction, which makes it an important location to study.

According to the Alberta Community Council on HIV (ACCH) and Alberta Health Services (AHS), there were 687 accidental overdose deaths related to opioid use in 2017, which constitutes an alarming 40% increase since 2016. In 2016, AHS announced funding to support harm reduction strategies to address the crisis—strategies include the dispensing of naloxone kits and supervised consumption sites their aim is to minimize death, disease, and injury related to problematic substance use (ACCH, 2018). More recently in November of 2020, they revised their policy on harm reduction for psychoactive substance use with the intention of promoting a recovery-oriented response that is to be used by all provincial health care providers who care for

[69] The specific location in which the research takes place is not disclosed in order to protect the privacy and anonymity of the participants and the agencies where they are employed. The limitations of concealing the specific research location are discussed in section 4.5 of this chapter.

patients who use psychoactive substances, including illegal substances and legal substances such as alcohol, tobacco, and prescription drugs (AHS, 2020).

4.3.1 Recruitment and Sample

Once approval was received from the University of Ottawa's Social Sciences and Humanities Research Ethics Board, (see Appendix A), I began to recruit a sample by engaging in what Blaikie (2000) refers to as single-stage non-probability sampling—more specifically, judgment/purposive sampling in combination with snowball sampling. Through previous contacts in the social work field, I recruited frontline workers employed with harm reduction programs. There is some debate surrounding the (dis)advantages of the researcher being known to the participants, but previous familiarity between them has been documented as an effective way to build trust and rapport (Dickson-Swift et al., 2009). I did not solely recruit participants with whom I had a professional relationship, although most of them were known to me in some capacity. Similar to the argument put forward by Johnston and Kilty (2016), I argue that these connections strengthen the research because I was seen to be "in the know" and had common ground with the participants (p. 182).

Stebbins (2001) notes that conducting 10-12 interviews is common because of the more labour-intensive nature of this method (p. 28). Based on this suggestion as well as discussions with my supervisor, my goal was to conduct a minimum of five (5) and a maximum of ten (10) interviews, although only five were conducted due to limited availability from interested parties, especially within the first six months of the COVID-19 pandemic.[70] Inclusion criteria required

[70] When I began to conduct this research in the late summer of 2020 after the outbreak of COVID-19, it was clear that frontline workers were experiencing new stressors and challenges related to the pandemic's impacts in the health and support sectors, as well as on personal levels related to mental health. It is understandable that participating in research was not feasible for many at that time.

participants to be employed as social support workers with harm reduction programs that serve either pregnant individuals, mothers, children, or families in the geographic location. While I did not exclude workers who were employed at the same program, I attempted to recruit participants from multiple programs that explicitly claim to use harm reduction, so that I would be able to explore the similarities and differences in approaches across the included service providers.[71]

The types of clients whom participants support was intentionally broad when I began recruitment because there is inherent value in finding similarities and differences across these programs based on the clients they claim to support (e.g., Is the primary client the mother, the child, the family unit? How does this shape perceptions and subsequent service provided?). Secondary to this, I was not yet able to determine the access that I would have to frontline workers in programs that solely support mothers, for example. By including a wider range of clients (i.e., mothers, pregnant people, and/or families), it was more likely that I would meet the minimum number of participants that I sought to interview, which allowed for a fruitful yet feasible analysis.

4.3.2 Collection Strategy: Interviews and Content Analysis

Interviews were the primary data collection strategy used for this research, with content analysis of program descriptions constituting a secondary form of analysis. Program descriptions and mandates that I obtained online (from public websites) were compared and presented in relation to the conceptualization of harm and client need at the onset of the first analysis chapter (see section 5.1.1). Using a search engine on my internet browser (www.google.com), I typed in terms that included the specific program name and the location of the program. I clicked on search results that had links affiliated with the larger organization in which the program exists/is

[71] Two of the participants work at the same program and have the same title.

located, if available.[72] The links either brought me to the program page (the program name was the title with descriptions below) or the main page of the larger organization, where I scanned for the program names or other keywords including "About," "Learn more," "Find out more," and "Referral." Qualitative content analysis[73] was useful to recognize the similarities and differences across programs and analyze the meaning and themes embedded in latent content, which allows for more contextually placed and fruitful findings in this qualitative study (Schulenberg, 2016).

As I planned for and carried out interviews for this project, I considered issues related to the potential participants' risk, privacy, confidentiality, and consent, as well as their health and safety especially considering the outbreak of COVID-19. Interviewees were given the option to participate in interviews in-person with safety measures in place, virtually via Microsoft Teams or Zoom, over the phone, or in writing.[74] Five semi-structured interviews took place in the Fall of 2020: two were held in-person, two took place virtually, and one was written. I received consent from all four of the oral-interview participants to audio-record our exchanges.

Participants were given the interview guide and consent forms in advance of their interviews so that they could have ample time to review their contents and ask questions. Throughout[75] the research process, I provided space for the participants to discuss any concerns with me and I reassured them that they could withdraw at any time before, during, or even after our interview. They were given the opportunity to provide feedback in advance of their

[72] Program 1 (P1) did not have an official program page through the larger organization, but there was a general page related to the types of services provided in their addictions' programming, so I utilized content on that page as well as content on a third-party site that referenced the larger organization (see Appendix G). Based on my own notes and knowledge from my time in frontline work, as well as the participant's (Participant A) description of the program and the description on the broader (official) service provision page, the content seemed to be accurate.
[73] I drew upon Braun and Clarke's guide to thematic content analysis, discussed in detail in section 4.4.
[74] Interviews that took place in-person were physically distanced and I made efforts to ensure that the participants who chose this option were comfortable and did not prefer an alternative interview format. All in-person interviews occurred in accordance with provincial health guidelines in place at the time.
[75] Prior to, during, and after the interviews.

interviews by specifying any questions they preferred not to answer. I attempted to minimize the risk of coercion or undue pressure to participate throughout the recruitment process especially as I built rapport with the participants. I also took steps to ensure that interview data would be stored securely and to communicate those steps to the participants both in the consent form and again before their interviews.[76] To protect their anonymity, I used pseudonyms in interview transcripts and also suggested that they refrain from using employee emails in their communication with me to protect their confidentiality at their places of work.

The participants were advised of risks related to emotional or psychological discomfort prior to the interview and during the consent process. Additionally, they were told that they could take breaks at any point during the interview and that they have the right to refuse to answer questions that they do not feel comfortable answering without fear of reprisal or unfair treatment. After the interviews, I made sure to ask how the participants were feeling and I provided them with a list of mental health resources in their area.

As a gesture of inclusivity (Mander, 2010), each interviewee was given the opportunity to review their transcripts so that they could ask for amendments in any areas where they felt that their intended meaning was not properly captured. Transcript review acknowledges the importance of the participants' perceptions and constructions and as such, it constitutes an attempt to conduct ethical research and validate findings (Mero-Jaffe, 2011). Providing the participants with their transcripts is a gesture that aligns with the Tri-Council Policy Statement for ethical research by underscoring freedom of choice, consent, and ethical research principles related to justice and respect for persons (TCPS 2, 2018). Each participant reviewed their

[76] The interview data (audio recordings, interview transcripts) are being stored on a password-protected computer for a period of 5 years since the interview date, as is suggested by the Research Ethics Board in accordance with University of Ottawa Policies and Procedures, Research Sponsors' Policies and/or Requirements, professional and field-specific standards and Applicable Laws.

transcripts (excluding Erin because she typed her interview responses); however, they did not choose to amend any of the content.

4.4 Analysis Strategy

I engaged in a thematic content analysis through an inductive and directed approach, which tends to be used when there is limited or incomplete research on a particular topic (Hsieh and Shannon, 2005; Elo and Kyngäs, 2008). Although various literature exists on harm reduction, motherhood, and children's rights respectively, literature that considers the intersection of these topics from the perspectives of frontline workers is limited. Through content analysis, I was able to immerse myself in my exchanges with the interviewees so that new insights could emerge (Kondracki and Wellman, 2002). I often began with open-ended questions to explore the participants' understandings of general topics, and then I followed up with more targeted questions (pre-written in my interview guide) based on predetermined categories I had chosen before the interviews, as suggested by Hsieh and Shannon (2005).

I coded[77] the transcripts using Braun and Clarke's (2006) step by step guide to thematic analysis: first, I familiarized myself with the data by transcribing the interviews and reviewing my field notes. Second, I began developing categories that fit the data. Initially, I observed five (5) very broad categories from the transcripts related to (1) harm, (2) harm reduction, (3) barriers, (4) mothering and children, and (5) resistance. Third, I read through the transcripts to search for themes—I used colour-coded post-it notes to write down the emerging themes within each of the broad categories. Fourth, I reviewed and revised the themes as I reread the transcripts and fifth, as my codes became saturated, I created new ones with corresponding

[77] See Appendix H for a more detailed coding scheme related to the interview transcripts.

definitions/criteria. I continued with this iterative process of revisiting categories, codes, and definitions to reformulate and refine the themes with each additional reading of the transcripts.

Eventually, I transferred my post-it notes (codes, definitions, data/quotes) to Microsoft Excel so that I could better view and revise the codes (vertical axis) across participants (horizontal axis), whose quotes were listed in chronological order according to the recency of their interview. I continued to revise my codes using Excel's features to colour-code cells indicate connections between quotes, merge cells to indicate (potentially) overlapping categories, and insert cells with italicized text to leave notes to myself when I was not yet sure if I should rework the code in question.

I settled on six (6) themes that were informed by the literature and an emerging theoretical framework related to (1) (re)conceptualizing harm, (2) clients' histories of trauma, (3) harm reduction as not just a 'bag of stuff', (4) abstinence-based barriers as intersectional stigma, (5) mirrored tensions between harm reduction, elimination and balancing best interests, and (6) navigating tensions and overcoming barriers. I identified three broader themes within these categories, each of which represents an analytic chapter, namely (I) 'setting the (analytic) stage' (Chapter 5), (II) harm reduction as not just a 'bag of stuff' (Chapter 6), and (III) identifying barriers and navigating tensions (Chapter 7). Sixth and finally, I selected compelling quotes to be used in the written analysis portion of the project report/thesis. Braun and Clarke (2006) recommend choosing fitting examples that "capture the essence" of the issue you are discussing (p. 93).

In addition to the Excel sheet that served as my codebook, I created an Excel sheet to track the demographics of the participants and the programs with which they were employed. A

less detailed version of this sheet was reproduced for the purposes of this analysis and can be seen in section 5.1 (Table 1).

During the transcription and coding processes, and throughout the analysis, I took time to pause and reflect on my own personal and professional experiences and I explored how they either converged or diverged from the data codes. In addition to the reflexivity that I practiced internally, I wrote or typed notes on my emotional reactions and considerations related to interventions in order to help guide my analysis and alert me to my own biases; as Kleinsasser (2000) notes, reflexivity and writing are conjoined in research work. While such notes were destroyed for privacy reasons, writing still allowed me to display reflexivity through the "thinking and feeling" elements of emotion work, which Dickson-Swift et al. (2009) explain are necessary to account for the manifestations of emotion in research (p. 62). For example, as I began to code content related to harm reduction, I had to collapse sub-codes/themes, one of which was clients' histories of trauma. This code first emerged as a category within harm reduction, but by thinking and writing retrospectively about past clients with whom I had worked, their stories, and whether they aligned or departed from the interview content, I was able to draw awareness to my own perceptions and separate them from those of the participants. According to them, trauma seemed intertwined with harm and so, it belonged under the broader code of harm, as is seen in the interview coding scheme (see Appendix H).

Rather than attempt to eliminate bias completely—a task I feel is improbable—I used reflexivity to explore points of convergence and departure related to both client experiences and staff interventions so that I could gain a better understanding of my inclinations as a way to ground myself in the data without undue influence. By writing about my own emotional reactions as I listened to (and reread) the participants' words, I acknowledged that "we enter the

field first as human beings… we cannot stop ourselves from *feeling* in the research moment" (Hannem, 2014, p. 268). Additionally, practicing reflexivity through thinking, feeling, and writing together in a spiral like process (Mao et al., 2016) allowed me to ground the interview data, while still analyzing it through the theoretical lenses that were mobilized.

4.4.1 Mode(s) and Level of Analysis

I attempted to use inductive reasoning to code the data without the bias of my theoretical and personal preconceptions during the initial coding stages; however, Braun and Clarke (2006) note that researchers "cannot free themselves of their theoretical or epistemological commitments, and data are not coded in an epistemological vacuum" (p. 84). Some academics question whether a purely inductive approach is truly possible if researchers are unable to suspend their theoretical knowledge during analytic induction (see Bryman, 1992). I acknowledge that I likely did not fully set aside my knowledge of existing theories until the later stages of data analysis as the approach requires. Since I was analyzing the data with my previous experiences (both personal and professional) and knowledge (of many existing theories) in mind, I engaged in deduction along with elements of induction, which some say can both co-exist during the coding process (Schulenberg, 2016; Zhang and Wildemuth, 2017).

Deduction can be a helpful tool during qualitative content analysis to help with concept and theory generation (Berg, 2017). Quite early on in the coding process, I used deduction to explore the relevance and application of theoretical concepts related to stigma, resistance, and normalization, in some cases because the participants directly referred to certain concepts (e.g. during her interview, Participant C says that her clients just want to be "normal moms") and in others, because of my own experiences in the social work field, which led certain concepts to be more easily apparent to me. In addition to using both inductive and deductive modes of

reasoning, I analyzed the data at a latent level by attempting to go beyond semantic content to explore the hidden assumptions and beliefs that are embedded in the words themselves (Braun and Clarke, 2006). Such a level of analysis aligns well within a constructionist paradigm where the goal is to contextualize individual experiences within sociocultural structures (see Burr, 1995).

Although induction and deduction were most applicable to this thematic content analysis, it is important to acknowledge that I used certain elements of abductive reasoning as well. Reichertz (2013) notes that each of the three reasoning processes, that is induction, deduction, and abduction, do not exist in isolation and can be used together. An abductive analysis approach includes a component of speculation that must be accounted for, and it occurs regardless of whether we are aware of it or not (Tavory and Timmermans, 2014). Tavory and Timmermans (2014) contend that we can use abduction to speculate based on the signs (information) we pick up and the ways in which we construct and interpret these signs, and that such a process can be useful in qualitative research. In the constructionist paradigm in which I found myself working for this study, there is a view of life and research work as a continual process of recalibration. As I analyzed the transcripts and attempted to make sense of the interviewees' perspectives, I engaged in this process of recalibration using speculation. Abduction often seeks to make new discoveries and create new theories, but this goal need not always be fulfilled. By using induction and abduction together, I was able see if existing theories adequately matched the data, which they did—if they had not, then it would have been time to "discover something new" (Reichertz, 2013, p. 144).

4.4.2 Benefits of Transcription, Coding, and Field Notes

Although Alvesson and Karreman (2011) view the act of coding as belonging to a view that aims to passively mirror reality, Tavory and Timmermans (2014) explain that taking field notes, transcribing, and coding interviews work as a "check" against selective memories and cognitive dissonance (p. 53). Silverman (2005) also echoes the benefits of more detailed transcription and coding methods. In order to situate each interview, I took field notes before and immediately after the interaction, and while transcribing. These notes allowed me to contextually locate the way each interview unfolded. Tavory and Timmermans (2014) suggest that together, field notes, transcription, and coding using abduction are important ways to "guard against biased memories and the imposition of preconceived ideas on observation" (p. 54). I was unable to capture each movement or facial expression, although even if I had, my own subjectivities would inevitably colour my interpretation of their meanings; note-taking and coding are exercises that I used to draw awareness to my own judgements.

Since the interview itself is a product of interaction and the meaning I construct, attempting to contextualize and explain the meaning-making process as much as possible is important. This process of writing field notes, transcribing each interview without software, and coding in a highly detailed way allowed me to (re)familiarize myself with the empirical material. These strategies help to address the complexities of interview situations and increase the validity of research findings.

4.5 Study Limitations

This study has limitations that relate to the interview and language (section 4.5.1), stakeholder consultation, (section 4.5.2), and generalizability (section 4.5.3). The following

sections demonstrate an awareness of these issues, while also discussing strategies used to address them.

4.5.1 The Interview and Language Assumptions

It is important to acknowledge that the semi-structured interview guide used in this project shaped and constrained the empirical material that was produced (Alvesson and Karreman, 2011). I guided the participants through questions that I felt were relevant based on the literature and my own experiences, but by using a semi-structured interview guide, I attempted to create a balance between those questions and the potential insights that the participants may have wanted to share; moreover, open-ended questions allowed the participants to speak more freely.[78] Another limitation that relates to the interview guide is a lack of questions about the frontline workers themselves. In the interest of project feasibility and due to my own capacity and the professional nature of the relationship between myself and some of the participants, I asked only brief demographic questions about the participants. Individual testimonies and stories about their own lives could have made for a richer analysis that allowed me to explore how their personal experiences have shaped their perspectives (Mander, 2010), but it was outside the scope of this research.[79]

Some researchers have noted that there is a dilemma when studying any social phenomena that revolves around assumptions related to language (see Blaikie, 2000; Mander, 2010). According to Blaikie (2000), there are two choices that can be made by a researcher related to language: (i) adopting the interviewee's construction of concepts, or (ii) adopting a

[78] The nature of the written interview (conducted with the fifth participant) constitutes a limitation in this study because I was unable to ask follow-up questions related to the insights she provided. Offering this type of interview format was meant to be inclusive and respectful; however, it did not allow for deeper understandings to emerge.
[79] There are questions that would have led to a richer analysis related to the participants' lives and whether they are mothers, how they came to be frontline workers, why they chose this field, etc.

sociological construction of concepts based on the literature and your own understanding of it (p. 197). Although you can attempt to use both, there is no guarantee that the concepts will match up for your interviewees, which creates a barrier to interpretation and understanding. Since I had no ability to discuss interviewee constructions until ethics approval was obtained, I used a preliminary definition of harm reduction based on the literature and my past experience and remained open to the interviewees' constructions of harm reduction as I would go on to ask them to define and explain it.[80] I conceptualize harm and harm reduction based on the participants constructions in Chapters 5 (section 5.2) and 6 (section 6.1) respectively.

4.5.2 Stakeholder Consultation

Alvesson and Karreman (2011) explain that amplifying voices and assigning validity are issues that exist regardless of whether the researcher is aware of them or not. A significant limitation of this study is the lack of client and child consultation. I was not able to consult any of the clients whom the participants support or their children because of institutional policies protecting their privacy and confidentiality; however, future studies should aim to explore their perspectives. Their experiences as they define them are important and the intention of this work is not to project an experience onto these groups, but rather, to suggest best practices in frontline support based on the patterns and issues that frontline workers encounter in their own respective experience.

4.5.3 Generalizability

In order to protect confidentiality, the geographic research location and the programs where the participants are employed are concealed, which inevitably limits the contextual details

[80] The definition of harm reduction based on the literature is explicated in the literature review of this work (see section 2.6).

that can be shared and that could have been useful in the analysis of the interviews and a more detailed comparative analysis of the programs. Moreover, the small number of interview participants (5) in the research sample, as well as their differing roles and programs of employment, constitute limitations to generalizability. Despite the somewhat broad selection criteria that would seemingly make similar responses among participants less likely, there was consistency in the interviewee's perspectives, particularly in relation to the importance of harm reduction and the nature/types of barriers, which points towards theoretical saturation (Johnston and Kilty, 2015). To address the existing limitations and ensure that the interviewees' perspectives were as genuinely represented as possible, respondent validation can be helpful (Silverman, 2005). Allowing the participants to review their transcripts, as I outline in section 4.3.2, serves as such a means of validation. Additionally, it is important to note that within the qualitative tradition, the quantity of interviews leading to generalization is not the ultimate goal of research (Forman et al., 2008).

A criticism of the constructionist paradigm is that it is seen to be too subjective and therefore less valid because qualitative research does not lead to sweeping generalization, but as McAleese and Kilty (2019) also note, it is not meant to. It is important to note that some researchers problematize the idea of pure evidence in social science and point to the inherent value in experiential stories that have the potential to influence policy and lead to social change (Mander, 2010; Alvesson and Karreman, 2011; McAleese and Kilty, 2019). Thus, although conducting five (5) interviews may seem to be a limitation to generalizability, there is value in describing and explaining the experiences and constructions of people who work to support those who are marginalized. Furthermore, focusing on the "vivid details and deep nuances" can allow researchers to explore topics in meaningful ways (Johnston and Kilty, 2015, p. 60).

4.6 Chapter Summary

In this chapter, I have outlined the constructionist and feminist underpinnings of this work as well as the technical aspects of the methods related to research material, sampling, collection and analysis strategies, and limitations of the proposed research. The next chapter (Chapter 5) presents the analysis of the data based on the methods outlined in this chapter and the theoretical framework presented in the previous chapter (Chapter 3)

5. 'Setting the (Analytic) Stage': Participants, Programs, and Clients

This chapter begins with an overview of participant demographics in section 5.1 to situate the forthcoming analysis of the interview data; in section 5.1.1, I engage in a content analysis of publicly available website-based program descriptions and mandates.[81] In section 5.2, harm is not only conceptualized based on provincial legislation and the programs' broad mandates, but it is also reconceptualized based on an analysis of the perspectives that emerge from the interview participants. An overview of the clients and their unique challenges as told and understood by the participants is provided in section 5.3, which also presents a subtheme emerging from the interviews related to prioritizing the clients.

5.1 Contextualizing the Participants[82] and Programs

All five participants are frontline workers in the region who identify as female, with ages ranging from 28 to 46 years. The first participant (Participant A), who we will call Anna, is a counsellor who works quite independently from the broader organization in which her program is located; she is also completing a Master's degree in social work. The second participant (Participant B), Beatrice, is a registered nurse who works in a program associated with both the healthcare and child welfare systems in the province. The third and fourth participants (Participants C and D), Cameron and Demi, are both social workers who coordinate support services within the same interdisciplinary agency. The fifth and final participant (Participant E), Erin, is a program supervisor at a non-profit agency.

[81] The content details provided are minimal in order to protect the identity and anonymity of the participants and organizations, as well as their clients

[82] To protect the confidentiality and privacy of the participants, pseudonyms are used throughout this analysis.

The participants all support pregnant persons who are struggling with substance and/or alcohol use and mental health, except Beatrice who supports mothers and babies in the postpartum period, although her support is more short-term compared to the others. Like Cameron and Demi, Beatrice's support is not limited to substance/alcohol use and mental health. These three participants also support clients with a wider range of situations related to domestic violence, mental health, poverty/homelessness, criminal justice involvement—for Cameron and Demi, this support targets the prenatal (and sometimes post-partum) period. The table on the following page (Table 1) presents a general overview of the participants and the programs in which they work as they are described in this section. By considering the participants' roles[83] and the programs in which they work as outlined in Table 1, we can develop a greater understanding of how and why their perspectives may align on certain issues but diverge on others.

[83] The job titles of the participants vary and although this does limit comparative analysis and generalizability, it also strengthens the research by allowing multiple perspectives to emerge from women who work with similar client types (i.e. pregnant individuals and/or mothers who have just had a baby and are struggling with 'harmful' situations) in similar programs.

Table 1. *General Overview of Participants and Programs*

	Participant's Pseudonym	Years of Experience	General Role	Harms Addressed in Program	Client Types
PROGRAM 1	Anna (Participant A)	15	Counsellor	• Primarily addictions (substance, alcohol use) • Mental health • Other concurrent harms	Individuals during perinatal period
PROGRAM 2	Beatrice (Participant B)	25	Registered Nurse	• Substance, alcohol use • Domestic violence • Mental health • Other harms deemed as child protection concerns	Mothers (postpartum) and babies
PROGRAM 3	Cameron (Participant C)	11	Social Worker	• Substance, alcohol use • Domestic violence • Mental health • Criminalization • Poverty • Social isolation • Other harms	Vulnerable pregnant individuals
	Demi (Participant D)	5	Social Worker	• Substance, alcohol use • Domestic violence • Mental health • Criminalization • Poverty • Social isolation • Other harms	Vulnerable pregnant individuals
PROGRAM 4	Erin (Participant E)	11	Program Supervisor	• Primarily substance, alcohol use • Domestic violence • Gang related violence • Mental health	Individuals during perinatal period who are using, or used, substances or alcohol during pregnancy

5.1.1 Program Analysis

There are four different programs represented in this research—as mentioned previously, Cameron and Demi work with the same program. Each program explicitly mentions their use of harm reduction, except for Beatrice's program whose mandate implies that some harm reduction

strategies like safety planning are used without explicitly using the term of "harm reduction." These programs are among others in Canada that have emerged since the 1990's to meet the needs of pregnant persons, mothers, and children by reducing the harms associated with substance and alcohol use primarily, as well as other harmful circumstances (Nathoo et al., 2013; Marcellus et al., 2018). They are shaped by child welfare legislation but also by broader overarching goals that aim to protect children and support those who are pregnant or mothers.[84] The programs where the participants are employed attempt to improve outcomes for the populations they serve by using harm reduction approaches in varying capacities.

The web-based descriptions of the programs in which the participants work do not claim to support clients solely with one set of challenges, like substance use for example. The program mandates list more than one circumstance for service provision, although Programs 1 through 4 (henceforth referred to as P1, P2, P3, and P4) all mention substance use explicitly in their program descriptions, either as an issue or challenge for the target population they aim to support (P1, P3) that also requires assistance (P2) or as part of their program's eligibility criteria for clients (P4). Mental health is an area of need outlined by descriptions for P1, P2, and P3, but not P4. In its program description, P1's areas of need are limited to these first two categories of substance use and mental health.[85] The program is an initiative of Alberta's health system, and its services are focused on providing treatment related to mental health and substance use. Along with substance use and mental health, P2 and P3's focus areas also include domestic violence and other additional, yet differing, issues—for P2, these issues relate to maternal and newborn postpartum health, parenting skills, attachment, and safety and for P3, they include poverty, (lack

[84] To protect the confidentiality of the participants, minimal details are provided regarding program mandates and their emergence.

[85] While her program targets substance use and mental health according to its mandate, Anna lists additional areas beyond the program's mandate that she provides support for related to criminalization, violence, and relationships.

of) housing, relationships, and legal system involvement. It is important to note that Alberta's child welfare agency, namely Children's Services (CS), plays a larger role[86] in P2 relative to the other programs.

P2 is said to have emerged from attempts to create a model of child welfare based on prevention and safety maximization; herein lies a key difference between P2 and the other programs whereby P2 is largely abstinence based and the others utilize harm reduction. While Beatrice does use harm reduction at times (and she explains that she sees its benefit because of her previous work experience with a harm reduction program), she acknowledges that P2 is abstinence-based, which leads to barriers and tensions in support practices (see sections 5.5 and 5.6, respectively). P4 has substance use as its primary focus, but the description also mentions support for relationship building and access to resources related to housing, health, and the legal system. All the participants' descriptions of the issues addressed in their programs align with the web-based content that was analyzed, except for Anna who noted wider areas of support. The table below (Table 2) provides a comparative overview of programs' target areas based on their publicly available descriptions:

Table 2. *Program Target Areas (According to Posted Descriptions)*[87]

	Substance Use	*Maternal Health*		*Domestic Violence*	*Poverty/ Housing*	*Relationships*	*Legal System*	*Parenting/ Attachment*	*Newborn Health*
		Mental	*Physical*						
P1	●	●							
P2	●	●	●	●				●	●
P3	●	●		●	●	●	●		
P4	●				●	●	●	●	

[86] In order to protect confidentiality of Beatrice (Participant B), the 'larger role' of Children's Services in P2 (program 2) is not explored in any further detail.

[87] Recall that Participants C and D are employed with the same program (P3), and so there are only four (4) programs represented in this table.

In keeping with program descriptions that highlight at least two areas of 'harm' or 'need', the participants acknowledge that certain challenges do not exist independently from others, particularly those related to mental health, violence, criminalization, etc. Moreover, trauma is recognized as an important contextual component of their clients' struggles. The complex and 'tangled' nature of trauma and concurrent harms is important to note because although there is an emphasis within each program on substance use as the 'harm', or one of the 'harms' that programs are attempting to address or reduce, participants focused on trauma-informed approaches that center the client 'as they are' rather than on reducing substance use.

The insights and experiences of the participants have implications for far more than substance use alone and they point to the importance of trauma-informed approaches. In order to understand such approaches, it was useful to explore the program descriptions and mandates so that we can understand the participants' conceptualizations of harm based on the areas of need that they, and their programs, identify and address. To protect the confidentiality of the participants and their places of work, there will be a broader review of harm as a concept both through Alberta's legislation and policies, and according to the participants and the programs in which they work.

5.2 (Re)Conceptualizing Harm

Alberta's Ministry of Children's Services, commonly referred to as Children's Services (CS), is mandated by the province's child welfare legislation, namely the *Child, Youth and Family Enhancement Act* (2000) to protect children from harm and intervene when necessary for the best interests of the child. The term 'harm' is not explicitly defined or cited in the *Act*, but the legislation does specify when a child is deemed in need of intervention (s. 2), when they are neglected (s. 2.1), and when they are emotionally or physically injured, or sexually abused (s. 3).

Neglect, emotional and physical injury, and sexual abuse are all justifications for intervention. Substance use, alcohol use, mental health, and family violence are explicitly mentioned as causes for intervention when they lead to emotional injury of the child:

> (3) For the purposes of this Act, (a) a child is emotionally injured […] (ii) if there are reasonable and probable grounds to believe that the emotional injury is the result of […]
>
> (C) exposure to family violence or severe domestic disharmony; […]
> (E) the mental or emotional condition of the guardian of the child or anyone living in the same residence as the child; […]
> (F) chronic alcohol or drug abuse by the guardian or by anyone living in the same residence as the child.
>
> *(Child, Youth and Family Enhancement Act*, 2000, s. 3)

This legislation dictates that any person who has reasonable and probable grounds to believe that a child needs intervention based on the reasons listed above, among others, must report the matter to the appropriate authorities.[88] While the programs are attempting to reduce the harms associated with the situations listed above, employees, including the research participants, have a duty to report in these situations. It becomes clear that the implied (and broad) definition of harm in the legislation can be quite subjective in practice, especially with the recognition that child to parent separation can be deeply traumatizing for mothers and children (Humphreys, 2019; Ritland et al., 2021). The participants reflect on the "traumatic" (Demi) and "massive impacts" (Anna) that child apprehensions have on children and their mothers and in doing so, they highlight the tensions between CS's conceptualization of harm based on its justifications for intervention and an abstinence-based model and their own contextually-based (re)conceptualizations, which consistently show a marked departure from CS. Although some participants (Anna, Beatrice, Cameron) believe that it can be safe for children to remain with their mothers who use substances or have unhealthy partnerships, they specify that it does

[88] *Child, Youth and Family Enhancement Act*, RSA 2000, c C-12, s 4(1).

require those mothers to use harm reduction strategies, like safety planning for example.[89] They recognize the disproportionate impacts of stigmatizing policies on racialized and impoverished clients (see Chapter 7), yet they simultaneously acknowledge the need to ensure safety for children.

The participants were not asked to define harm explicitly in the interviews, but some acknowledged that harm can be linked to substance use, domestic violence, and other issues like mental health: Beatrice, Demi, and Erin acknowledge that there is harm linked to substance use, domestic violence, and other traditionally-harmful situations—indeed, there is a significant human cost for both mothers and their children (Sword et al., 2009) and their broader program mandates hope to reduce the potential impacts. These three interviewees suggest that the best possible outcome is a reduction in substance use for those who are using, or a client leaving a violent relationship, as Erin explains below:

> The goals of [the program] are to support women to reduce or stop alcohol and/or drug use during pregnancy, to achieve and maintain recovery, and to support healthy pregnancies and lives for women and their children.
>
> -Erin (Participant E)

Beatrice goes a step further to explicitly recognize that some circumstances are linked to harm for their children. Notably, she emphasizes domestic violence as often having an impact which may not be recognized or known to mothers, as seen by the excerpt of her interview transcript on the following page:

[89] This specific perspective related to safety being possible for children who remain in these environments is not reflected in any of the web-based program content. Note also that harm reduction and safety planning are discussed in the following chapter (Chapter 6), as are the complexities of providing client-centered support while also ensuring safety for children.

> If they choose to stay in the [domestic violence] relationship, then we educate them to make sure they understand the impact this is having on the baby. The tricky thing is that [mothers] don't always understand the impact the domestic violence has on the baby and their brain development. If the baby is in the room when the violence is happening, the effect that's having…Well, it's known that it causes […] physical changes in […] brain development.
>
> -Beatrice (Participant B)

There is a wide body of research that identifies the harmful impacts of family violence on children as they relate to behavioral, social, and emotional functioning (Edleson, 1999; Hazen et al., 2006; Howell et al., 2016; Fusco, 2017). Beatrice's perspective illuminates the larger issue of child protection and harm in the context of domestic violence, which can often be intertwined with issues of substance use, mental health, and of course, involvement in the child welfare and criminal justice systems (Rutman et al., 2020).

Demi does not explicitly discuss what she perceives as harmful, but she often refers to her clients "doing the work they need to do" to take their baby home, which involves things like "working through the recovery, being in stable housing, leaving an abusive relationship." While she does mention that she is in no place to push her opinion on her clients and assume that she knows better, she does mention that it is "unfortunate" that some of her clients are not ready to do the work that they need to do in order to take their babies home. Although Demi may not agree with a client continuing their substance use or remaining in a violent relationship because she wants them and their children to be safe in the ways that she and CS view safety, it is clear that she does not want to, nor does she, impose this belief on her clients unless they are ready to make changes.

The collective perspectives of these three participants are somewhat comparable to those featured in Benoit et al.'s (2014) study on service providers' constructions of pregnant and early parenting women who use substances in which providers' perspectives seem to be shaped by individualized and moral notions of substance use as problematic, rather than broader contextual

factors that lead to (and reinforce) substance use.[90] Specifically, Benoit et al. (2014) found that providers see any use during pregnancy as "fundamentally problematic" and harmful for reproductive (and biologically female) bodies despite a lack of wider evidence in support of their claims (p. 260). While these three the participants (Beatrice, Demi, and Erin) view substance use as problematic, they differ insofar as they appear to balance individualized and moral notions of what is considered problematic with an acknowledgment of client trauma and non-judgmental practice through harm reduction. They seem to make attempts to separate their own moral judgments from their roles and the support that they offer. They also demonstrate deeper understandings of contextual factors that lead to their clients being in what they consider to be problematic circumstances, which is shown when they reference clients' histories of trauma, their experiences with racism, or even different cultural understandings of violence as being acceptable from partners.

Unlike the other participants, Anna and Cameron never discuss moral notions of substance use as problematic and instead attempt to contextualize their clients' experiences and subsequent circumstances and reframe the mainstream conceptualization of harm. They attribute harm to the child welfare system and the barriers and stigma (in the system and outside of it) that pregnant persons and mothers who use substances face. Collectively, each of the five participants from this study, albeit in varying degrees, make attempts to contextualize the circumstances of their clients, whether those involve substance use or other 'problems' like domestic violence, adverse mental health, etc.

[90] It is important to note that the research sample in Benoit et al.'s (2014) study was larger (n = 56) than this study's (n= 5), and all of those participants were employed at the same program (HerWayHome (HWH) in Victoria, British Columbia, Canada); moreover, their analysis focuses on the main research question of how providers define problematic substance use among pregnant and early parenting women, which was not asked directly in this study.

While their perspectives depart from Benoit et al.'s (2014) findings related to substance use, they are consistent with another finding related to domestic violence where frontline community workers expressed that the dynamics of these types of violence are misunderstood and inappropriately dealt with by child protection workers (see Douglas and Walsh, 2010). The findings for this project are unique in the literature because they attempt to explore frontline worker perspectives on harm related to the intersections of multiple issues based on evidence that trauma, substance use, and violence are intertwined (see Poole et al., 2008; Hughes et al., 2011; Hovey et al., 2020).

5.2.1 Concurrent Harms: "There's Quite a Few Overlapping Now"[91]

The program descriptions and participant responses imply a recognition that challenges are often concurrent, especially with substance/alcohol use. Such perspectives align with an increasing awareness in the literature that populations who use substances and/or alcohol or who are experiencing homelessness have higher rates of concurrent disorders, many of which stem from histories of trauma (Sword et al., 2009; Strehlau et al., 2012) including historical and intergenerational trauma among Indigenous people in Canada (Nathoo et al., 2013; Ritland et al., 2021). Cameron gives an example of a client with concurrent challenges:

> When we first met with her, […] the concerns were [daily] meth use; she had drug-induced paranoia; she was in a domestic violence relationship; there was sex work; she was homeless.
>
> -Cameron (Participant C)

Cameron and others point to the significant impact of concurrent harms on their clients' abilities to navigate support services and access resources that fulfill basic needs. This insight is

[91] Excerpt of a quote taken from Anna's (Participant A) interview transcript.

confirmed by Statistics Canada research which shows that those with concurrent disorders in Canada have poorer psychological health and are more likely to have unmet needs (Khan, 2017).

Despite such challenges, there are still positive outcomes for some, like for Cameron's client above who, "through her own will […] got treatment, […] left her abuser, […] got housing, [and was] given the time to bond with her baby and just be a mom" despite "lots of bumps in the road" (Cameron).[92] All of the areas of concern that Cameron noted were overcome in this story, which is significant considering the barriers clients face and the rare times when mothers can overcome even some, nevermind all, of them.

5.3 The Clients: *"Histories of Trauma, Every Single One of 'Em."* [93]

The participants tend to offer perspectives that view client challenges and circumstances as manifestations of trauma. Every one of the five participants interviewed for this study points to their clients' "histories of trauma" (Anna). Erin provides the following insight:

> All I know is that trauma manifests in people in different ways… It [involves] mental health, addictions, behavioural concerns, criminal activity, *et cetera*.
>
> -Erin (Participant E)

The clients whom the participants support have a unique range of backgrounds and demographics and although the inability to access program statistics on clients (or more importantly, the inability to speak to clients directly) means that there are limitations in generalizing their demographics and challenges, certain commonalties emerged from the

[92] Although Cameron mentions that this client overcame challenges "through her own will," she clearly specifies later on in her response that there were other factors that significantly impacted the outcome for the client, like the empowering approach of the Children's Services worker who was involved. Cameron implicates wider factors outside of the individual's control that led to this positive outcome. Moreover, her anecdote leads us to understand that although others may also have the 'will' to change their situations, there are factors beyond their control that can (and often do) shape outcomes. These factors or barriers are discussed further in Chapter 7.

[93] Excerpt of a longer quote taken from Anna's (Participant A) interview transcript.

interviews and are supported by the literature—trauma is perhaps the most glaring. The participants often discussed or pointed to their clients' traumatic experiences in some way.

Anna explains that most of her clients have low levels of income and education, although she does see some who have higher levels of both. The other participants shared similar observations with regards to income levels. Both Anna and Erin explained that their clients are usually using either alcohol or substances—as Anna says, "they have that addiction piece." Beatrice, Cameron, and Demi also support clients who use substances and/or alcohol; however, their programs are not primarily targeted toward substance use, so addiction is not a prerequisite for program participation. All participants, whether they support clients with addiction or not, remarked on their clients' struggles with domestic violence. Mental health is another common struggle that often presents concurrently and "can really affect [clients'] day-to-day functioning and their ability to [do the things they need to do]" (Demi). Other common circumstances that clients live with include involvement with the criminal justice system, lack of housing, poverty, family detachment, social isolation, and significant stigmatization, whether on the basis of those circumstances alone or their intersection other factors like race. Anna notes that over half of her clients are Indigenous and struggling with intergenerational trauma and the child welfare system, which she contends "follows the particular trends of most systems" in Canada that have harmed and continue to deeply harm them. Demi also provided an anecdote of her Indigenous client's struggle to find housing as they continue to experience racism and stigma from proprietors who allegedly do not want to rent to them because they are Indigenous.

In light of the client population served by the frontline workers interviewed, it is important to consider the result of colonization.[94] Due to colonization, Indigenous women in particular face immense and unique forms of gendered violence and trauma (Department of Justice, 2017; NIMMIWG, 2019) and they are often targeted for intervention by the child welfare system (Veenstra and Keenan, 2017; Thumath et al., 2021). The overrepresentation of Indigenous people in the criminal justice system and Indigenous children in the child welfare system is evidence of a long history of oppression and cultural erasure (Sinha and Kozlowski, 2013; Caldwell and Sinha, 2020). Punitive and abstinence-based interventions harm women who use substances and face violence and poverty stemming from trauma, meaning there is a disproportionate impact for Indigenous women and children who struggle with intergenerational trauma.[95]

5.3.1 Client Needs: "Their Needs Are Everything." [96]

Interview questions about client needs and challenges were often met with pause. One pause was followed with an "Oh god" from Anna and an "Oh man" from Cameron. Despite their years of experience working in the field, or more likely, because of their experience, this question did not have a straightforward response. After their thoughtful pauses, the participants went on to describe various needs that their clients have, which include, often first and foremost, financial support and housing. It appears that many of their clients need support with what Demi

[94] I acknowledge that I am a non-Indigenous person situating this project in literature and theories that reflect colonial knowledge and practices. Despite my intentions to demonstrate critical thought and to utilize Indigenous sources in academia, this work is still heavily grounded in academic traditions that reproduce dominant worldviews. I do not intend to present this analysis as a solution to the injustice that Indigenous people continue to face; rather, I hope to highlight relevant theoretical explanations that apply to this project and may allow for theory and practice in frontline work to be bridged through trauma-informed approaches to improve circumstances in some tangible way.
[95] The barriers that Indigenous families face related to structural stigma and subsequent discrimination are discussed further in detail in Chapter 7.
[96] Excerpt of a quote taken from Cameron's (Participant C) interview transcript.

calls “high-level resources” like finances and food. Because of their pregnancies, they support clients with accessing medical care regardless of their history of care (i.e., regardless of whether they have seen a doctor prior to or during their pregnancy). If the clients want parenting support or education, which many do, participants will refer them to outside programs and also provide some education to their clients in a way that aligns with their own knowledge and capacity (e.g., as a Registered Nurse, Beatrice can provide medical education in a way that differs from the education that Cameron would provide as a social worker).

As Erin explains, clients often need emotional and financial support, as well as support with their addiction or recovery, trauma counselling, conflict resolution, employment, parenting capacity, and creating healthy boundaries, although needs are not limited to these areas. Supporting clients in these areas also means navigating the many barriers and systems that are inherently discriminatory. The COVID-19 pandemic has also increased barriers and led to more challenges for clients who have more unmet needs than before. Cameron explains:

> In this time, we’re seeing a lot of clients that have risk factors in every area…They’re sleeping rough…in tents or on park benches. They’re using. They’re with people that are abusing them… They’re not doing any prenatal care because access to medical care is different and there’s a lot more barriers now… There’s no food for them. Their mental health isn’t being treated… Right now, [the program] is looking at very high-need, high-complex files.
>
> -Cameron (Participant C)

The outbreak of COVID-19 has led to many global public health measures including social distancing, limiting non-essential business and travel, and increased precautions in the health care sector and beyond. Some of the participants’ discussions of COVID-19 align with the literature, which highlights the disproportionate impacts of the pandemic and government responses to it on those who use substances and those experiencing homelessness, poverty,

stigmatization, or marginalization, many of which may be co-occurring (Green et al., 2020; Perri et al., 2020; Ali et al., 2021).

Beatrice explains that her role does not look any different as a result of the pandemic because her services are considered to be essential, but she does notice one shift in particular:

> Nothing has really changed, except… we do a lot of home visiting and since the pandemic, some of the moms are really reluctant to have us come into the home. [With] some of them, we have to wear full gear, like a face shield and gown cause they just don't want us in there, which I get.
>
> -Beatrice (Participant B)

The comment above shows that receiving certain types of support during the pandemic under the guise of child protection, which is not always voluntary depending on the program, can be difficult for mothers who have their children's best interests in mind and want to keep them safe and healthy. It also lends support to countering an image of mothers who are involved with children's services as being risky, unfit, and selfish because of their substance use or other circumstances (Boyd, 1999; Kilty and Dej, 2012).

Demi also commented on the ways that a lot of her clients manage the barriers that the pandemic has exacerbated, particularly if they already have other children:

> With COVID…, programs are shifting to phone calls [instead of coming to the clients], but if they have to go into appointments [and] they have children, then it's an extra barrier [because] someone needs to watch the kids or I have to bring all these kids with me… It's a lot more time and effort for the client or myself, [but] a lot of clients are pretty good […] if they already have kids, like usually they have somebody… who can take care of them.
>
> -Demi (Participant D)

Her comments affirm the self-determination of her clients and point to the support that some of them have in caring for their children, but it also seems to apply to clients whose children remain in their care. Their needs and the challenges that they face are likely quite different than others who have had their children apprehended and have not regained custody.

5.3.2 (Prioritizing) The Clients

> We obviously have a legal obligation to make sure that that kid is safe, but our primary client is that pregnant person… My job is to make sure the pregnant person is safe and doing as well as they can be… and if [their] child is apprehended, we still work with them.
>
> -Demi (Participant D)

When asked about the main client type that they support in their program, the participants (except Beatrice who works with mothers and newborns) identify the pregnant person as their primary client, as is evidenced by Demi's quote at the beginning of this section. In doing so, they acknowledge the human value of the client, regardless of his, her, or their pregnancy, and regardless of the fetus.[97] They attempt to reduce the harm for the client and also ensure that they are receiving appropriate medical care and education if possible to allow for the best outcomes for both client and child, but they are there for that client. Although the reason that these clients participate in the programs is their pregnancy and to produce better outcomes for newborns, the client is afforded the respect and dignity of priority. This prioritizing of the client is a key theme that is prevalent throughout the interviews and embedded in many of their responses. In a society where they are stigmatized and often assigned less value than their children or others who do not have the same challenges, the participants repeatedly acknowledged their clients' humanity and value, even when they do things that would disappoint others or get them "kicked out of [another] program" (Cameron). In doing so, participants disrupt the problematic, yet often dominant and implied, perception that sees women[98] "primarily as foetal incubators and primary

[97] Given the various complexities resulting from substance use in utero, there are numerous nuances to consider, including ones related to the type of substance. Although these are beyond the scope of this study, to illustrate such complexities, literature is briefly presented related to positive outcomes of harm reduction when used post-partum; see Paynter (2019) for a commentary on breastfeeding and its positive impacts on birth weight, for example, even when the mother is using substances (s. 7.1.1 in this work).

[98] The term 'women' is used here to preserve the original matter from Benoit et al.'s (2014) research; however, in this context, it is meant to be more inclusive and to denote not only those who identify as women, but all gender identities and expressions of persons who have biological reproductive organs required to carry a fetus/become pregnant.

caregivers of infants" (Benoit et al., 2014)—incubators whose natural instincts are expected to help them abstain from substance use while pregnant and to be caregivers who are completely engrossed in their children's lives above all else (Campbell, 2000; Kilty and Dej, 2012).

By prioritizing the client (i.e., the person who is pregnant), the participants practice an act of resistance against what Foulkes (2018) refers to as the irrevocable rupture and separation of mother and fetus (p. 238). This socially constructed separation emerges from and continues to be intertwined with the hierarchical situating of gender in the West which sees the White male as the norm: the subject that all others are compared against (de Beauvoir, 1949; DiQuinzio, 1999). de Beauvoir (1949) writes:

> He is the Subject, he is the absolute — she is the Other… [What is a] Woman? Very simple, say those who like simple answers. She is a womb. An ovary; she is female: this word is enough to define her.
>
> -Simone de Beauvoir[99]

The gendered perspective that de Beauvoir describes has justified the medicalization of childbirth, where the freedoms of women or persons with biological capacities to become pregnant are ascribed less value than fetuses. Risk factors related to fetal exposure to substances, despite their considerations being quite narrow and overly simplistic, have come to justify punitive strategies against women or pregnant persons (Foulkes, 2018). As Anna explains:

> Everyone wants to know. Everyone is so curious. *Well how does this affect the fetus? How does that affect the fetus?* […] In the same breath, they're like, *but we want to be harm reduction …* If you're harm reduction, that shouldn't matter.
>
> -Anna (Participant A)

The psycho-biological development of children who are exposed to substances in utero is impacted by a wide variety of factors and as Foulkes (2018) suggests, must be understood in the

[99] The quoted content is an excerpt from de Beauvoir (1949), pp. 26, 41.

context of the social environment. In Boyd's (1999) interviews with mothers who use illicit drugs, the participants explained how professionals often suggested that their children had neonatal abstinence syndrome. The children's problems were blamed on the women's drug use and their perceived maternal failings in protecting them—there was no consideration of the impacts of socioeconomic deprivation on the children's health (p. 104). Furthermore, some of the participants explained that creating an environment where mothers are fearful and blameworthy, and children are removed from their homes has severe impacts (for both mothers and children) that must also be considered.

As she continues to point out problems related to a medicalized model (as per her quote above), Anna asks, "what about the impact of child-parent separation on the child?" Along these lines, Beatrice tells me that "children need their moms," with Anna and Cameron pointing to mothers also needing their babies.[100] Although Children's Services (CS) claim that their goal is to keep families together, according to Cameron, "they're [CS] not giving moms the tools to be able to do that," as they should be according the *Convention of the Rights of the Child*, which specifies that the state must provide appropriate assistance to parents so that they can fulfill their child-rearing responsibilities in accordance with the best interests of the child (OHCHR, 1989, Article 18 subsection 2). It seems that the pressure and fear that mothers feel due to CS emerge from intersectional forms of stigma within this abstinence-based system that focuses on micro-level individual factors while ignoring wider macro-level contexts (discussed further in Chapter 7). Working as professionals coming from a harm reduction perspective seems to allow the participants in this study to hold more contextualized understandings of their clients' circumstances, which allows for approaches that prioritize women/persons even when children

[100] The impacts of child and parent separation are discussed in Chapter 7 (see section 7.1.2.).

are involved because of the positive impacts that this priority can have on both mothers and their children.[101]

All of the participants suggest that assigning priority to clients or at least providing more directed support to pregnant persons or mothers is crucial to ensure best outcomes for children, even Beatrice, although she is the only participant who specifies that her clients are both (and in equal measure) mothers and children. Cameron clearly summarizes this shared perspective through her emphasis on the importance of prioritizing clients, which may result in benefits for their children:

> We're always gonna be there for the mother and I think if more programs worked that way, it would impact the baby because if the mom is doing well, the baby is going to do well… A lot of the programs and services only focus on that baby and baby's needs and they're not doing anything to help the mother, so it's setting the mom up for failure, which then in turn, as we know, has an impact on baby.
>
> -Cameron (Participant C)

As an experienced frontline support worker who has spent 11 years in the social work field (five of those being in her current position), Cameron often expresses her frustration at the state of the current child welfare system. She suggests that far too often, she sees her clients left unsupported and misunderstood by other frontline workers who work from abstinence-based understandings. These understandings may emerge from good intentions to protect children from harm, but in practice, they create barriers for mothers that punish them rather than support them. Abstinence-based programs can lead to punitive responses like apprehension or criminal charges that negatively impact mothers, but they also have consequences for children who are learning and

[101] While harm reduction seems to allow participants to hold more contextualized understandings, this study does not evaluate harm reduction and abstinence comparatively. Future studies should aim to explore the perspectives of those who work within an abstinence-based program or agency, including CS in Alberta.

developing based on the nurturing experiences that their parents and communities are providing and shaping for them.[102]

Under the *Convention* (OHCHR, 1989), all children have rights to safe, healthy, and full lives, and protecting those rights is the responsibility of not only their parents, but societies, governments, and communities.[103] Despite its supposedly shared nature, Rich (1986) explains that the responsibility for children is heaviest for women who are held accountable for all aspects of their children's life and whose status is questioned if they are seen to have failed their children (pp. 52-53). By prioritizing the client, participants acknowledge the unequal responsibility which emerges from and exists within the patriarchal and colonial child welfare, criminal justice, and healthcare systems that disproportionately impact women/persons who are impoverished and racialized.

Also embedded in discussions of client priority are the participants' implied perceptions of the (in)compatibility between women's needs and children's rights. Women's interests and children's needs are often positioned as diametrically opposed, with children's needs being used as the main justification for support of women with children (Marcellus, 2004). Cameron explains in her quote at the beginning of this section that when women are doing well, children are inevitably going to have better outcomes. With this comment, she seemingly tries to justify support for women because it will help children, but interestingly, this moment is the only one of its kind in her interview and it emerges from her argument that programs that focus solely on children's interests should also focus on mothers to ensure better outcomes for children. She

[102] Barriers related to abstinence-based approach are analyzed in Chapter 7 of this work.
[103] Refer primarily to the following sections of the *Convention on the Rights of the Child* as they relate to all children's protection from discrimination (Article 2), children's inherent rights to life (Article 6), health (Article 24), and recreation/play (Article 31), and the responsibilities of parents and the state to provide for the best interests of children (Articles 3, 18) (OHCHR, 1989).

acknowledges the value of her clients' needs and their children's needs, suggesting that prioritizing client needs does not take away from the needs of children—rather, it is more likely to impact them in positive ways. Even when asked directly whether it is difficult to provide harm reduction support when children are involved, she answers in terms that apply only to the women she supports, saying it is difficult because it complicates things for her clients when systems are largely abstinence (i.e., harm elimination) based. Anna similarly resists against the tendency to position women's needs and children's needs as diametrically opposed. Like Cameron, she finds fault with the systems that contribute to further harm and unmet needs for families and agrees that prioritizing clients is itself important because of the inherent value of clients as persons and because of the impact it can have for children.

As the only participant in this study whose clients include both mothers and their babies[104], Beatrice focuses more on the impact that certain circumstances, like domestic violence, have on children. Her arguments for improved support for women rest on various justifications that prioritize children's needs. Beatrice's perspective represents a departure from that of the other participants who outwardly asserted that their focus is primarily on adult clients, not their client's children (although all participants do have a duty to report to Children's Services in certain situations to protect children).[105] Given Beatrice's background in public

[104] The web-based content obtained for Beatrice's program (P2) refers more often to the needs and support of babies, rather than that of mothers or families. While Beatrice specifies that both mothers and children are her clients in equal measure, the program content points towards children being the primary 'clients'.

[105] It is not my intention to suggest that the other participants feel that the development of children is not important, nor do I mean to represent research on child development as insignificant—on the contrary: first, the other participants seem to be hyperaware of the devastating effects of inadequate support, especially when it has emerged (and continues to be reproduced) within a system that stigmatizes mothers in circumstances (e.g. using substances, in violent partnerships) that intersect with trauma and histories of oppression (Cottler et al., 1992; Driessen et al., 2008).

health and her role in assessing and supporting babies, it is not surprising that her perspective mirrors that of the medical model with a focus on child development.[106]

Anna and Cameron are particularly clear in explaining that the punitive and abstinence-based nature of the child welfare and criminal justice systems do not help children or their mothers, but rather, perpetuate harm especially for populations that have histories of oppression from these systems. Literature which suggests that policies must move beyond criminalization of these populations and towards changes in the child welfare system (Poole and Isaac, 2001; Nathoo et al., 2013; Ritland et al., 2021) and the interview responses in this study demonstrate overwhelming support for harm reduction approaches; however, misunderstandings of harm and harm reduction remain a barrier to such changes (see Chapter 7, section 7.1).

5.4 Chapter Summary

In this chapter, I 'set the stage' for the forthcoming analyses by contextualizing the participants, programs, and clients and discussing themes related to the participants' reconceptualization of harm and assigning of priority to mothers as clients, both of which emerge as best practices to ensure the interests of both mothers and children. The following chapter (Chapter 6) explores the participants' definitions of harm reduction and the corresponding themes that emerge from the interviews related to building the client-worker relationship, the stages of change, and the role of the frontline worker in harm reduction approaches.

[106] Research in the area of child development is important, particularly given that its intention is to protect children and their rights. This research inevitably guides Beatrice's good intentions to protect children and prevent additional harm in their lives; however, the recommendations that emerge can end up being harmful to the children we are trying to protect, especially when an abstinence-based system mandates the separation of children from their mothers without considering trauma and historically-informed alternatives. These issues are explored further in Chapter 7.

6. Harm Reduction: "*Not Just a 'Bag of Stuff*"" [107]

This chapter presents the theme of harm reduction as not just a 'bag of stuff' and begins with an examination of the definition and perceived importance of harm reduction approaches (6.1) followed by a comparative analysis of the roles and experiences of the participants.

6.1 Overview of Harm Reduction

The participants construct harm reduction as an approach to practicing frontline work that is client-centered and non-judgmental, similar to the service providers in Lee and Zerai's (2010) study. As Erin explains, there is a recognition embedded within harm reduction approaches that acknowledges and accepts that "many aren't in a position to abstain" from substance use or other potentially harmful things. This definition is consistent with that of Harm Reduction International (n.d.), the Canadian Drug Policy Coalition (n.d.), and much of the harm reduction literature (see Riley et al., 1999; Ritter and Cameron, 2006; Nathoo et al., 2013). The dominant focus of such literature is substance use, although there are arguments in favour of expanding the harm reduction agenda and using its approaches for domestic violence or sex work for example (see Gauthier et al., 2014 and Cusick, 2006, respectively). Both this dominant focus in the literature and a wider utilization of harm reduction strategies are corroborated in the interviews where harm reduction is "usually associated" with substance use, as Demi says, but the participants acknowledge (and some of their programs specifically mention) using a harm reduction approach for other harms presented by their clients. Although all the participants provide support related to substance use, which is the main or one of the main mandates of their

[107] Excerpt of a quote taken from Anna's (Participant A) interview transcript.

programs, harm reduction seems to be understood as a much broader way of engaging, supporting, and approaching people.

Throughout their interviews, each of the participants provided examples of concrete harm reduction strategies, the most common of which is safety planning (also referred to as relapse prevention planning). Used for multiple circumstances related to substance/alcohol use, domestic violence, homelessness, sex work, criminal justice system involvement, and mental health, safety plans are created and periodically reviewed in collaboration with the client to try and reduce the harms associated with a certain situation/lifestyle/act that is occurring or that may occur in the future. In relation to substance use for a mother who is not yet ready to stop or reduce their use, a safety plan would outline steps that ensure their child/children are with a safe and sober person, while the client uses substances away from them.[108] Cameron provides some questions that she asks when creating a safety plan to allow the client to think about their triggers and what may be helpful to them in difficult moments, including but not limited to substance/alcohol use:

> How do you know when you're not doing well? How will we [frontline workers] know when you're not doing well? What steps can you take for yourself and then what steps can we take to support you? […] How do we know when we need to reach out to other professionals?
>
> -Cameron (Participant C)

Participants help to create safety plans in similar ways for many harmful situations, the exception being domestic violence which only Beatrice addresses specifically. She says safety planning for domestic violence (where the mother is actively involved with a violent partner) includes putting "emergency" steps in place and asking the client where they can go and who they can call. For this type of harm, there seems to be less of a focus here on the client's triggers, or even their partner's triggers, because they can be unpredictable. Although safety plans can be

[108] Cameron and Beatrice both provide this example of safety planning for substance use.

helpful for some, Anna and Cameron mention that there are more complex and transient clients who are "just trying to survive day by day [and] for them, a piece of paper with [steps to take] … it's not gonna happen" (Cameron). In these cases, Anna tries to support their basic needs and provides the following anecdote of a client who had recently given birth, which serves as a helpful introduction to the following sections related to building the client-worker relationship (section 6.2), the stages of change (section 6.3), and the role(s) of the frontline worker (section 6.4). Moreover, this story invites us to think about harm reduction outside of the usual discourse related to safe consumption sites (substance use) and having police on speed dial (domestic violence):

> She was using meth and cocaine throughout her pregnancy [and] she wasn't ready to make any adjustments to that. She was honest about how much [she used] and when… It was actually really impressive… she was really really honest, which a lot of clients have a very difficult time being. And that's fine, because […] I don't need [to know]—it's not about the drugs anyway. I can see the way it's impacting their lives whether [they] tell me or not, so it just doesn't really matter, but [her honesty] was interesting. So, then we just talked about other stuff…
>
> -Anna (Participant A)

Already, we can see that embedded in this story is evidence of a relationship between Anna and her client that has been built slowly, based on non-judgment and honesty.[109] Anna allows the relationship to be guided by the client. The continuation of the anecdote below provides us with concrete examples of harm reduction strategies that were relevant for this client's circumstances.

> …We talked about what was she missing and she said she couldn't sleep a lot…
>
> -Anna (Participant A)

[109] Anna came to see this client's decision to be honest about their substance use as an act of resistance and while this should be explored in future work, it is beyond the scope of this study to examine the complexities of such an interpretation.

Immediately, it is apparent that the support that Anna provides is guided by the client's own perceptions of her needs. Anna's use of the word "we" throughout her storytelling is evidence of the dynamic of their relationship—it is intended as a partnership.

> …[I asked what we could do and she decided that if she uses at 5PM instead of 8PM, she should be able to fall asleep by 10PM so we moved towards that.] [In relation to] feeding herself, [she decided that] instead of getting up and using, she would get up and have a yogurt and then she would use. We're trying to get food in the system, we're trying to get sleep in the body, we're trying to eliminate some of the stresses…
>
> -Anna (Participant A)

As Anna switches from "we" to "she" when describing the course of strategies to be used, she affirms the client's agency by assigning her ownership over her choices. At this point in the story, we also see how harm reduction strategies can take on many forms. Sometimes, harm reduction just means getting an extra 2 hours of sleep or eating something when you otherwise would not have, which may mediate negative health outcomes for both mothers and thus, their children.[110]

> I also did some counseling between her and [her] mom [to] raise mom's awareness about harm reduction and […] why this was the best approach for her daughter at this point, just really trying to make that environment more harmonious and hit all those other major life areas. [We worked] with her doctor to have conversations about alternatives if she wanted any [for her use] or for anxiety or depression because she was open to hearing different options. Let's make sure you have everything you need and all the people that you need that can help with different things…
>
> -Anna (Participant A)

As this quote demonstrates, the role of the frontline worker is multifaceted. Anna's role requires her to collaborate with and engage other supports, both 'natural' (as they are referred to by Anna and other social workers to describe family and friends, for example) and professional

[110] Poor sleep is associated with adverse outcomes related to maternal mental health (e.g., postpartum depression) (Dorheim et al., 2009; Okun et al., 2018), which can negatively impact children (Trussell et al., 2018).

(e.g., healthcare professional), which shows that protecting the best interests of both mothers and children requires the participation and integration of multiple sectors.

> And it took quite a while cause she was quite resistant to having other people involved. I think she—she felt [pause] very stigmatized in the past and so it was […] difficult for her to trust me. I think she sort of felt like [she] finally found [a support worker] that 'works' [laugh], whereas I was like *no we need to diversify this group* [laugh] which we did eventually and she's really trying hard to build relationships with other service providers.
>
> -Anna (Participant A)

Aside from providing a practical example of harm reduction strategies, the above anecdote from Anna speaks to many elements that characterize harm reduction approaches, which include the relationship between worker and client, centering the client wherever they are, and acceptance and non-judgment, all of which are discussed in latter sections of this chapter. It also speaks to the trauma and stigmatization that this client has faced and why harm reduction can be useful because it creates space for support that acknowledges those harms to react in appropriate and trauma-informed ways, as both the participants and the literature suggest (see Marcellus et al., 2018; Nathoo et al., 2016).

Based on the interviews, it becomes clear that harm reduction is not necessarily "one thing" or a "bag of stuff"[111] as Anna says—it is not meant to be the same for each person. An important distinction that Cameron clearly explicates is that harm reduction is whatever the client in question needs it to be:

[111] Anna's mention of harm reduction as "not just a bag of stuff" was chosen as the title of this section because it represents an important theme that emerges in the interviews and throughout this analysis. Harm reduction encompasses a wide variety of values, beliefs, and practices, despite mainstream discourse which conceptualizes it as naloxone and safe injection sites, primarily. A recent example of this discourse is evident in Alberta premier Jason Kenney's (2021) tweet announcing new treatment spaces (see the post here: https://mobile.twitter.com/jkenney/status/1467923580683841538?s=10). While treatment spaces are needed and this announcement constitutes a positive step forward in some ways, Kenney (2021) mentions that "harm reduction, on its own, is not enough" and in doing so, shows a very limited (and misunderstood) conceptualization of harm reduction which, as the participants' experiences and perspectives demonstrate, is a massive barrier to improving circumstances for families.

> It really does meet clients where they're at. It provides an environment of no judgement… It's really just client-centered and it's trying to keep them safe and healthy in the best way that they identify.
>
> -Cameron (Participant C)

Cameron's perspective above is echoed by all the other participants who each emphasize the importance of acceptance and client-led support when practicing harm reduction. The strategies that frontline workers provide are part of a larger practice that acknowledges the intrinsic human value and self-determination of clients who are often treated as if they do not have either[112]:

> [Harm reduction is] a way of approaching a human that respects their humanity and also their individuality and their autonomy. -Anna (Participant A)

> It's very much just going along with their journey… it's their life and their choice. -Demi (Participant D)

> [Harm reduction] provides people with a choice of how they will minimize harms through non-judgmental and non-coercive strategies. -Erin (Participant E)

These quotes reflect a feminist ethic of support and treatment, which Marcellus (2004) explains holds space for broader considerations of autonomy in the context of perinatal substance use and provides responses that are voluntary and nonpunitive, rather than coercive and punitive.

When I ask about their opinion of harm reduction, all the participants express that they feel it is important and constitutes the most realistic and successful way of working with their clients, especially when abstinence/harm elimination is considered the alternative. While the participants discuss harm reduction in terms of client benefits, Demi also mentions the economic benefits of harm reduction strategies for substance use, along with the human ones:

> It costs the cities and taxpayers way less money and it actually saves more lives, so I definitely think it's important to use and work from.
>
> -Demi (Participant D)

[112] Pregnant persons and mothers who live in situations considered to be harmful are uniquely stigmatized. The treatment and stigmatization of these populations (the participants' clients) will be discussed further in Chapter 7.

Indeed, there is significant evidence[113] supporting the financial cost-effectiveness and positive human impact of harm reduction interventions in Canada and beyond (see Ritter and Cameron, 2006; Wild et al., 2017). Whether Demi's comments demonstrate a personal sense of pragmatism, her awareness of the political landscape in the province in which she works,[114] or perhaps both, by trying to explain the value of harm reduction in economic terms she highlights an important area of contention that exists with regards to adopting harm reduction policies in Canada. While there is research in support of harm reduction and its benefits related to human and economic costs, societal attitudes, values, and discourses surrounding it tend to serve as barriers to its wider implementation (Wild et al., 2017).[115]

Despite a "substantial evidence base [that] should translate into relatively straightforward policy support," discussions surrounding the incorporation of harm reduction services continue to be dominated by a moral and political focus rather than an evidence-based one, especially when these discussions involve people who use substances (Wild et al., 2017, p. 10). It is precisely these populations who need interventions that acknowledge their humanity and value, but because dominant discourse fails to recognize the contextual factors associated with substance use, they are highly stigmatized and judged. As Anna notes, "addiction is […] one of the last socially acceptable things to judge someone for."

Three of the participants (Anna, Beatrice, and Cameron) explicate harm reduction as being "the only way" to move forward in an effective way and to work with their clients—it is

[113] While I discuss the limitations of a biopsychosocial model which relies on the use of evidence as objective truth in section 2.4.3, I do acknowledge the value of research that contextualizes sociohistorical factors and biases, as is demonstrated by Wild et al. (2017).
[114] Demi (Participant D) mentions Alberta's political landscape and acknowledges its conservative nature in her interview.
[115] As Wild et al. (2017) note, there is a type of "*morality policy"* in the health sector whereby policymakers or politicians are resistant to evidence-based arguments.

essential in relationship-building between the frontline worker and the client. As Beatrice clearly explains:

> [Harm reduction is] the only way… For marginalized women, I honestly think it's the only way that you can build a relationship with them of work with them.
>
> -Beatrice (Participant B)

All of the participants contend that harm reduction is necessary to ensure better outcomes for mothers and children, with some (Anna, Beatrice, and Cameron) explaining that children can be kept safe even when they remain in situations that are seen as harmful. In the latter case, participants also implicate the safety of children as a guiding value in their outlooks. As such, they strive to meet their clients where they are at while also recognizing that if the client is not ready to implement harm reduction strategies like safety planning, then the child is not safe in that home. In this regard, complexities arise given the acknowledgment of client context (related to trauma, disproportionate impacts of stigmatizing policies, and systems of oppression) and the devastating impacts of child apprehension.

Cameron speaks directly to such a tension when she explains that very few of the clients she has come across intentionally and maliciously abuse and/or neglect their children; she reports that there have been some instances, but very few. Most of them, she says, just want to be "good moms," but they do not have the support needed to overcome barriers that emerge from abstinence-based systems. She understands that children cannot remain in unsafe situations, yet she also struggles when children are removed by an agency (Children's Services) that creates many of those barriers which impact marginalized mothers and children most significantly. This concern is one of the reasons that harm reduction is so important in ensuring outcomes that are in the best interests of both mother and children. Such an approach is predicated on the relationship

between the worker and the client, which emerges as a theme in all of the interviews and is consistent with harm reduction literature (Sword et al., 2009; Marcellus et al., 2018).

6.2 *"Just by Listening"*: Building the Client-Worker Relationship

> [The relationship's] huge. That's the only way that we can build trust; it's the only way they're gonna work with us… We build relationships at the beginning just by listening to them… We listen to their story… We don't tell them everything we know because we want to hear what they have to say. And if they tell us something that's not true, we don't, well, I don't take that personally. I take that as I haven't earned their trust… I don't have the right to know that yet and that's okay.
>
> -Cameron (Participant C)

Cameron's quote above encapsulates the non-judgmental attitude needed to practice harm reduction and the importance of the service-provider – client relationship in such practices. Anna and Demi also point to the ways that they prioritize relationship building and the maintenance of the relationship with their clients, as does Erin, although in her case as a supervisor, it is explained as part of the program rather than as part of her own experience. Interestingly, Beatrice explains that using a harm reduction approach is the only way that relationships can be built between she and her clients; however, due to her role working within the child welfare system, she is not always able to provide harm reduction strategies when Children's Services (CS) is involved. This comment suggests that she attempts to build relationships with clients, but when she is unable to practice harm reduction (which occurs frequently when children are at risk of being removed), the relationship suffers.

The relationship between the client and the worker is mentioned as an important aspect of harm reduction in the literature (see Sword et al., 2009; Nathoo et al., 2013; Marcellus et al., 2018), but its significance is especially evident in qualitative work like that of Rutman et al. (2020) where pregnant and parenting women who use substances and face multiple vulnerabilities discuss their appreciation for their workers who listen to their histories and are

sensitive to their experiences (p. 10), as the frontline workers in this study also strive to do. In their interviews, clients from Rutman et al.'s (2020) study, and providers from this study alike, choose to talk about the relationships that they form with one another and the meaning of trust in receiving and giving support. These collective insights underscore the significance of the relationship and trust-building between provider and client, both of which emerge in this study as being key to potentially reducing harmful outcomes in the future, although, as I demonstrate next, there must be detachment from such outcomes and acceptance of meeting the client "wherever they are."[116]

6.3 The Stages of Change: *"When They're Ready"* [117]

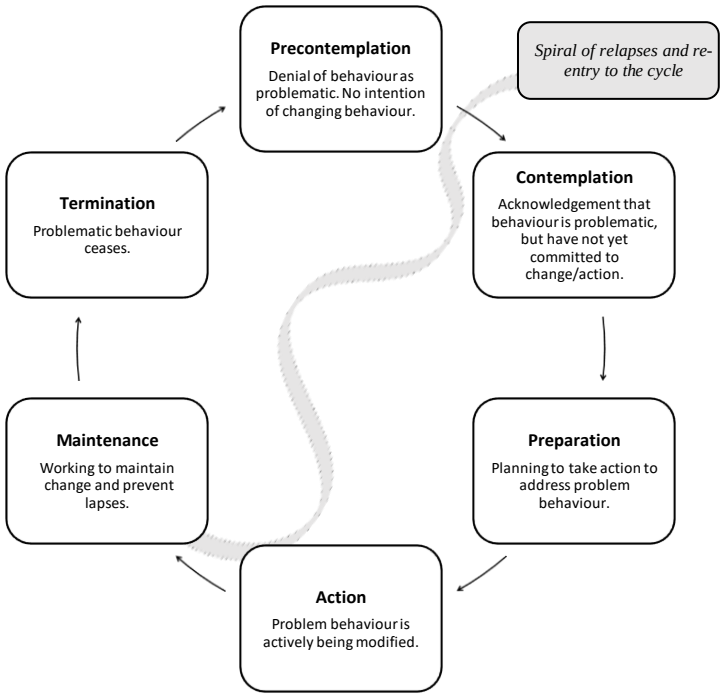
> It's about us keeping them alive… not just keeping them alive, but building a relationship with them of meaning where, when something shifts for them, they have places to go to or resources they've practiced using or you know, some, some… I guess hope that those positive interactions lead to some belief in self and some efficacy.
>
> -Anna (Participant A)

Demi's quote in the title of this section and Anna's quote above implicate Prochaska and DiClemente's (1992) stages of change (see Figure 1 below), which are referenced explicitly by some of the participants and frequently used in mental health and addiction treatment (Sutton, 1996; Migneault et al., 2005).

[116] While it was not examined here, it is relevant to consider the role of emotions in the relationship between (and experiences of) clients and frontline workers, particularly when prior research shows how emotions shape counselling practices and disclosure (Kilty and Orsini, 2019). Kilty and Orsini (2019) examine emotions in the context of HIV disclosure, but their methodology can be applied to wider situations related to readiness for change and emotion management.

[117] Excerpt of a quote taken from Demi's (Participant D) interview transcript.

Figure 2. *The Stages of Change: An Overview*[118]



The stages of change are relevant to harm reduction approaches, the latter of which are meant to be incremental and based on dignity and compassion, emphasizing the importance of client-centeredness (Marcellus et al., 2018).[119] The participants point to their attempts to meet clients in whatever stage or level of readiness they are in by accepting them for who they are, and wherever they are without judgment. Recent harm reduction literature seems to refrain from mentioning these stages of change, although there are some exceptions (e.g., Shlonsky et al., 2007). Research instead tends to draw on a central element of those stages, namely people's readiness for change (see Poole and Isaac, 2001).[120] Comparatively, the participants in my study

[118] Adapted from the works of and Prochaska and DiClemente (1992) and Prochaska et al., (1994), the latter of which includes a figure titled "The Spiral of Change" (Figure 1, p. 49).
[119] See also section 2.6 of this work for more on harm reduction as it is defined in the literature.
[120] Poole and Isaac (2001) do not reference Prochaska and DiClemente's (1992) stages of change, but do refer to women's (and mothers') movement through different stages of recovery and self-awareness related to their substance use.

often refer to their clients' readiness for change without discussing stages of change explicitly; regardless of how they refer to it, the stages of change seem to play an integral part in how they offer support, as well as what constitutes support.

Although the client's readiness for change is said to be influenced to some degree by the presence of supportive relationships, both professional (e.g., frontline workers) and natural (e.g., family, friends, partners), there is an acknowledgment that centering the client without judgment or expectation means not pushing them to change, even if not changing would mean keeping their children in their care. Two distinct perspectives on success in relation to change emerged from the participants' discussions on readiness for change:

Figure 3. *Two Differing Perspectives on Success*

(1) Success as Change (2) *Success Undefined*

(1) Success as Change

Success as eventual abstinence (e.g., from substances/alcohol, violent relationships) and 'healing'; change as the goal—see Figure 3(1).

When discussing readiness for change, some of the participants imply that this 'change', whatever it may be, is the ultimate goal—even if they explain that they do not push clients to make changes before they would like to or are ready to, it is clear that they hope their clients will one day live healthier and happier lives as they move towards healing rather than harm. In this scenario, clients would be able to keep or regain care/custody of their children and raise them in supportive ways. To accomplish this goal of success,

clients can move at their own pace towards healing from past and current traumas and abstinence as they receive support to overcome the many barriers that they face.

(2) Success Undefined

Goal as defined by the client; success/change in relation to the goal as determined, if at all, by the client—see Figure 3(2).

An undefined view of success is less common among the participants and only emerges from Anna's interview and at times, from Cameron's. This perspective is unattached to success as a predetermined concept and refuses (while also constantly fighting against urges[121]) to define it. Whatever the client identifies as their goal, if they have a goal at all, is the frontline worker's job to support; whether programs, professionals, or the public choose to label this goal as success is arbitrary.

The first perspective is consistent with some aspects of previous research where providers saw abstinence as the main form of success (see Benoit et al., 2014). The second perspective outlined above and in Figure 3 demonstrates an awareness of what some have pointed to as the problematic social construction of the ideal mother and the unequal and discriminatory manifestations of such a construction for mothers who are Black, Indigenous, or Persons of Colour (BIPOC), poor, and/or who use substances including alcohol (see Rich, 1986; Kilty and Dej, 2012; Boyd, 2019). In doing so, this perspective aligns with previous research where providers' reconceptualized success separately from abstinence through client-centeredness (see Lee and Zerai, 2010). Based on the literature and the participants' perspectives, it seems that meeting these populations where they are without imposing goals that have emerged from the

[121] Reflexivity is an important element of frontline work that emerges from the interviews and is discussed later in this section.

medicalization and professionalization of motherhood is crucial in practicing harm reduction. Although the second perspective aligns more closely with a theoretical harm reduction approach, human nature and all that shapes it creates nuances in practice. Frontline support workers must contend with the interplay of personal and structural influences as they attempt to help clients in or through their challenges. Important insights emerge from the interviews related to the participants' experiences and how they view their roles as workers practicing harm reduction.

6.4 The Multifaceted Roles of the Frontline Worker

The formal roles of the participants differ based on their program and job title—for example, Beatrice is a Registered Nurse who focuses on providing postpartum care to mothers and babies, while Anna and Erin specialize in service provision related to addictions and mental health (as a counsellor and team lead, respectively), and Cameron and Demi provide outreach for a wider scope of circumstances like domestic violence and social isolation. As was previously discussed, overlap occurs in all of these situations as harms do not exist in isolation; moreover, despite the differences in their formal job titles, all of the participants emphasize that their focus is on helping people address harm in realistic ways, rather than striving to eliminate the harm altogether. Much of the interview data suggests that harm elimination only serves to create new harms and challenges rather than helping the individual to navigate existing harms with better support. The insights from the participants point to recommendations for best practices[122] in frontline work related to advocacy, transparency with clients, and reflexive practice, all of which are inextricably linked to harm reduction frameworks.

[122] Best practices include approaches that are more likely to have benefits for clients, including those related to stronger relationship with workers that are built on trust. By strengthening relationships, it seems that outcomes are more positive in terms of prevention and productivity. I acknowledge the complexities that arise when using the term 'best practices'. See Osburn et al (2011) for a more detailed discussion of its connotations and nuances.

6.4.1 Advocating for Clients: "We'll Fight, I Mean, Advocate with Children's Services" [123]

Four of the participants specify that they "advocate" for clients, especially when they are unable to do it for themselves.[124] Sometimes, this advocacy takes the form of providing education and information to others who may be involved like support workers, family members, and especially CS workers. Demi's reference to 'fighting' in the title of this section implies that advocacy most often occurs as a means of resisting what CS deems as an appropriate course of action. Beatrice explains that advocacy is often needed when CS is involved not only for mothers, but for children as well. This sentiment is clearly conveyed in her statements below:

> I really try to advocate for the mums and the babies too […] cause they're better off with their—with that primary relationship […] but again, at the end of the day, Children's Services make that decision.
>
> -Beatrice (Participant B)

At this point in her interview, Beatrice is discussing clients who relapsed in ways that align with their relapse prevention plans (which she says is what CS "wants") [125], but their children are apprehended anyway. Her comment suggests that she often disagrees with CS decisions to apprehend children but feels helpless in her role to impact or change the decisions of child welfare to keep mothers and children together. Demi and Erin share this perspective—for them, CS decisions seem to be immovable at a certain point (when substance use is involved, advocacy seems to only go so far). In relation to this issue, Anna and Cameron's perspectives seem to

[123] Excerpt of a quote taken from Demi's (Participant D) interview transcript.
[124] The fifth participant, 'Erin', did not mention the term 'advocacy' directly in her written interview responses, though she does discuss various forms of support for clients that are trauma-informed and she acknowledges the judgement, stigma, and other barriers for which clients require support. Because of the written format of her interview, it is possible (and I would speculate, even likely) that further probing could have occurred for certain questions that would have allowed her to expand upon her responses related to her support.
[125] Relapse prevention plans often include steps to take if relapse occurs; for example, leaving one's baby with a safe and sober person. Beatrice is discussing protocols that CS seems to follow with clients who have relapsed and acknowledges that the steps above are what CS would "want" (Beatrice) to occur in the event of a relapse, particularly when the alternative would be leaving the child alone or in the same space where relapse occurs.

differ from the rest of the participants. Anna, who was completing her Master's degree in social work at the time of the interview, takes a critical perspective that is reportedly reflected in her academic work. Cameron is not yet a graduate student though she hopes to be one day, but like Anna, she tends to provide a perspective that is shaped by more critical thought. Although the other participants hold powerful perspectives that take contextual understandings into account, in instances related to CS involvement and advocacy, it appears that Anna and Cameron feel as though decisions may not be so final, especially if frontline workers act as catalysts for clients to find and express their own agency. Similar to the providers in Kilty and Orsini's (2019) study, Anna and Cameron see themselves as having the potential to influence outcomes, not by changing CS 'mind' but by empowering clients to work within the system and exercise all of the rights afforded to them.

Anna provides an example of a client who also took the steps that CS 'wanted' her to take in relation to her substance use, like we see in Beatrice's example in the previous paragraph. Both stories have the same 'ending' (removal of children from their mothers), but Anna paints a detailed (and heartbreaking) picture as seen from her critical lens, which alerts us to the importance of deeper understandings that function symbolically, but also practically in support settings. The story Anna tells me (paraphrased) is as follows:

> Anna has known this client, who we will call 'Alex', for many years through different programs. Alex's mom struggled with addiction and CS was involved when she was younger. She did not use much through her pregnancy (maybe only a few times) and her baby was apprehended.
>
> She reached a point where her perspective on life really changed. Her father passed away and other things had gone on. After the apprehension, she stopped using and went to treatment, she was consistent with appointments, she cleaned up her house and kicked everyone out who was not going to be healthy and her baby was returned to her.
>
> "She did all of these wonderful things and her life was changing and blossoming. She had goals and she was thinking of the future." -Anna (Participant A)

> Alex had her baby back for three weeks, but because of past CS involvement, she had to go to court virtually (due to the pandemic). In court, the CS lawyer and the judge refused to dissolve the Temporary Guardianship Order (TGO) that had been in place because the judge said that people like her need to be sober longer.[126] They said that they were coming in three hours to take her baby, and so she just sat there at home for three hours until they came.
>
> "They took her baby [...] and I mean, they broke her heart. They crushed her spirit. She left the house because she didn't know what else to do with herself. She was going mad, she said… She ended up using and binging for a few days and now [CS has] used that as another excuse [not to return her child] because, you know, clearly she can't handle life [sarcastic emphasis]." -Anna (Participant A)
>
> Since Alex relapsed after they took her baby, the case worker wanted to review her relapse prevention plan.
>
> "[The case worker] wanted to know what she'd done wrong, so we let them know what she'd done wrong and that was trust them—trust them when she was told that she didn't need a lawyer for her court appearance. We made it very clear in her relapse prevention plan how she will support herself from now and it had literally nothing to do with changing anything she was doing. I really tried to acknowledge to Alex, like, this was not you." -Anna (Participant A)

The anecdote above is disappointing, but not unusual, and it speaks to issues within the system that may not be changeable from where Anna and other frontline workers stand but can be resisted in some ways by the worker who advocates for their client to exercise their rights. Having a lawyer present is a step in the right direction as we have seen in the recent past in Alberta with another Temporary Guardianship Order (TGO) court case.

In 2020, Alberta's Court of Queen's Bench (QB) overturned a provincial court decision and set precedent requiring trial judges, not Child Welfare (i.e., CS), to decide the terms of access agreements between guardians and children (Legal Aid Alberta, 2020). Under a TGO, a child may be returned to their original guardian after a reasonable amount of time if that guardian has done what is required to regain custody of the child based on the plan of care.[127] The CS

[126] Under Alberta's *Child, Youth and Family Enhancement Act*, A TGO may be put in place whereby a CS Director is appointed as the child's guardian for a certain amount of time until a final decision is made regarding the child's guardian. The court can dictate terms related to the assessment of the previous guardian, mandatory courses that this guardian must complete, etc.

[127] *Child, Youth and Family Enhancement Act*, RSA 2000, c C-12.

Director (i.e., the person appointed as the guardian of a child) is responsible for creating this plan of care (formally known as a Service Plan) unilaterally, giving them much of the power to make decisions that significantly impact families (Legal Aid Alberta, 2020). This is troubling in a child welfare system rooted in a colonial and patriarchal forces that manifest in discriminatory and unjust treatment for poor and racialized women/persons with uteruses who use substances (Boyd, 2015).

Although Alberta CS still dictates the plan of care, the 2020 ruling overturned a previous decision that allowed the CS Director to ultimately decide visitation terms when the guardian and the Director could not agree on those terms. Since this decision, it is now clear that both CS and the child's guardian must decide visitation terms together and if they cannot agree, the ultimate decision is made by the court (creating space for a guardian and their lawyer to advocate for their child's best interests to the judge). The CS Director in the 2020 court case filed a service plan that listed the end goal as being a Permanent Guardianship Order (PGO) for the child, which contravened the purpose of the TGO to return the child to their home after a reasonable period if conditions are met. According to Legal Aid Alberta (2020), TGOs were being treated by CS in Alberta as an "administrative step leading to a PGO" (para 6) which is in contravention of the law and deeply troubling in terms of mother and child separations.

Obtaining a lawyer, or even having a support worker who understands and critically questions the systems in which they work, can clearly be beneficial to clients, as Anna's story and the 2020 court case suggest. A frontline worker could help with both tasks, the latter for obvious reasons, and the former because clients are entitled to legal aid lawyers to support them, especially when they cannot afford private counsel, but navigating the legal aid paperwork in a system that has disadvantaged them may be overwhelming. Advocacy is embedded in the role of

frontline support workers and this advocacy can be a means of fighting against unjust systems even when working within the confines of such systems.

6.4.2 Acceptance, but also "A Lot of Transparency" [128]

The participants discuss transparency, which Harm Reduction International (n.d.) outlines as a key feature of policies, programs, and practices that utilize harm reduction, as it relates to the possibility of apprehensions and the nature of CS involvement. As frontline workers who meet primarily with clients who are pregnant, Anna, Cameron, and Demi explain that they strive to be as transparent as possible with their clients about CS involvement and the likely outcomes that may occur after birth depending on the circumstances.[129] Demi explains:

> It's our job to have a more frank and upfront conversation... If [clients] don't go to treatment, then we need to talk about how Children's Services are likely going to apprehend [their] child… just having those honest, transparent conversations…because we never want [CS] involvement to be any sort of surprise or something that blindsides them. Unfortunately, we are on a timeline, so if [clients] aren't ready to change, that's okay for where [they]'re at, but just know that these are the consequences.
>
> -Demi (Participant D)

Anna similarly explains that she "[tries] to be honest about the system and its flaws," with Cameron mentioning that honesty is not meant to scare them, but rather to be transparent about a system that is not transparent to them. Through their honesty by way of explicating systemic flaws and their unjust nature to clients, the participants practice a form of resistance that is characterized by their "understanding of institutional oppressions that women experience" (Faulkner and MacDonald, 2009, p. 14). Unlike the other participants, Beatrice does not mention transparency, but this omission may be

[128] Excerpt of a quote taken from Cameron's (Participant C) interview transcript.
[129] Like Beatrice, Erin does not discuss transparency and honest conversations in her written interview. This may be due in part to the written nature of the interview and/or the comparatively different role that Erin has as a team lead rather than a support worker who primarily works one-on-one with clients.

due to the fact that she does not meet with mothers before their babies are born, so she does not have an opportunity to discuss such possibilities in her role.

Despite this difference in roles, all participants point to tensions that arise surrounding the practices of CS and other abstinence-based agencies and the participants' own attempts to support clients through harm reduction—in other words, there are tensions between the participants' acceptance of the clients wherever they are (as mentioned in the subheading) and the substantive consequences that emerge from a punitive system, the latter of which require transparency. There is a sense that most of the participants feel helpless in many ways because of CS policies and practices. In their roles, they must contend not only with their own jobs of supporting clients in non-judgmental and accepting ways, which requires constant reflexivity (discussed below), but also with systems that are inherently set up to disadvantage clients who use harm reduction rather than abstinence.

Although the participants express their frustration at a discriminatory system, the sense of helplessness seems to persist and often co-exists alongside their individual acts of resistance. Because of their roles as support workers, it is difficult to influence system level changes. As Anna says:

> It's really hard to work at the bottom of the system where you can't enact any change. Well, you could, but [we] don't have the time.
>
> -Anna (Participant A)

Support workers like Anna and the other participants are often overwhelmed with case files and they must devote much of their time to helping clients meet basic needs. Anna and Cameron mention that this devotion involves working collaboratively with other programs and support workers, which is needed to improve access and wraparound support for vulnerable populations.

As they discuss collaborative work with other agencies and staff, these participants draw attention to the importance of self-reflection in their work.

6.4.3 Reflection

Reflection is an important element of frontline work that emerges from the interviews. Each of the participants seems to demonstrate their own attempts to be self-aware and to practice reflection, albeit to differing degrees and for different reasons. Anna's reflection takes on a distinctly reflexive form. When asked who stigmatizes clients, Anna answers frankly:

> Oh gosh Danika, […] so many—who stigmatizes them? Everyone. The entire system. I can do it unless I am really checking in with myself.
>
> -Anna (Participant A)

With this quote, we can see Anna simultaneously acknowledging the power that she holds while also recognizing the potential for perpetuating harm when self-held beliefs and judgements are not questioned. On the other hand, Beatrice, Cameron, and Demi's reflections seem to occur as a means of maintaining a healthy balance between their support for the client, the client's agency, and their own healthy boundaries. The self is still implicated in the second perspective as the participants attempt to create boundaries for their own sake which will allow them to remain emotionally stable so they can continue their work. The wellbeing of the client co-exists alongside (but is likely prioritized above) that of the frontline worker as we observe an emphasis on acknowledging and empowering the client's agency—in other words, the intention is to provide the client with a sense of what Cameron refers to as "ownership" over their own lives and choices, whatever those may be.

The aforementioned reflections are intended to respect the rights of the clients while also maintaining a sense of responsibility by practitioners, but again, this balance manifests in

different ways. My initial inclination as a researcher is to ascribe higher value to Anna's reflection as it has been positioned against those of the other participants, but upon further analysis, it seems more appropriate to recognize the value of both in a non-hierarchical way, especially given the potential for positive impacts when practices of critical thought, reflection, and boundary setting are combined.

Anna's Reflection can be observed through her critical thought, i.e., her assessment of Alberta's child welfare and criminal justice systems, both of which she sees as contributing to what Toner (2009) refers to as the "vilification" of women who use drugs, especially racialized women (p. 163). We also see her critique of mainstream understandings as she highlights the social construction of women who use substances, especially women who are pregnant and/or mothers. Anna's words often denote the intersectional elements of gender, race, and class alongside clients' identities as substance users, as mothers, as persons without homes, etc.[130]

Beatrice, Cameron, and Demi's Reflection as a Means of Self-Protection is evidenced in their attempts to empower their clients' own senses of agency, while also creating boundaries for their own safety (emotional and otherwise) as frontline workers as a means of self-protection and coping. Cameron explains how there is a continuous process of reflection and negotiation that occurs to ensure a proper balance between client agency and her own boundaries:

[130] Anna's practices may constitute an attempt to "expose, […] strive against, [and] oppose" (Wade, 1997, p. 25) the oppression that clients face and as such, they could constitute forms of resistance according to Wade's (1997) definition. In interview conversations, Anna had also alluded to some clients' own behaviours as "acts of resistance"; however, given the limited scope of this study and the relatively few examples mentioned, it was deemed that more comprehensive theorizing of resistance was not feasible within this thesis. Nevertheless, in light of the interesting dimensions noted, it has become apparent that future research should explore the various manifestations of resistance from the perspectives of both frontline workers and clients. For further reading on some potential conceptual directions in this regard, see Bosworth (2001); Munn and Bruckert (2010).

> It's a constant balance of asking, *what is my part in this and what do they own*? I can give them tools… but they also have ownership over their choices… [As] a worker, it's hard not to carry some of the choices that they make with you.
>
> -Cameron (Participant C)

As she reflects on and negotiates her own boundaries, Cameron affirms her clients' sense of agency and ownership over their own choices. Boundaries are necessary, especially in frontline work where vicarious trauma and stress are likely to occur (see Choi, 2017). Additionally, agency seems to be an important aspect in support and recovery, as we see in Kilty and Dej's (2012) study where previously imprisoned mothers who used substances drew attention to the choices they were able to make to end their substance use and how they had decision-making power. The women's ability to renegotiate their identities, especially in difficult times, allowed them to remain hopeful and exercise some power over their addictions (p. 13). By recognizing their clients' agency, the participants empower clients by acknowledging the systemic barriers they face and the discriminatory nature of maternal blame.

The participants' practices of reflection in harm reduction seem to directly oppose CS's approach, which focuses on the immediacy of fulfilling requirements related to abstinence in order to protect children.[131] The interviewees' perceptions suggest that in practice, a medicalized system that blames mothers for perceived individual failures and subjects them to pressure and fear rather than understanding and support does not protect children, but rather, increases the likelihood of apprehensions which have significant impacts for both mothers and children.[132] Cameron notes that her clients, even those using substances, experiencing poverty, dealing with trauma, etc., are good mothers and want the best for their children; she specifies:

[131] I acknowledge that this study was not comparative and did not explore CS workers' perspectives.
[132] Intersectional stigma as a barrier and its impacts on children and mothers are discussed in more detail in Chapter 7.

> Our moms are always concerned about [their children's] care. They don't believe that a stranger is going to provide the same maternal care that they would and I would agree.
>
> -Cameron (Participant C)

The quote above points to reflection that balances client agency and the boundaries of frontline support workers) as a powerful tool that can empower clients and protect participants so that they can continue to work in the support sector effectively. Additionally, when combined with the reflexive elements of Anna's practice, reflection can draw awareness to systemic flaws that support persons and clients must navigate, offering potential for change.

There may be powerful possibilities for positive impacts when considering participant reflections, whereby a bridging can occur between theoretical understandings (that acknowledge the social construction of women from an intersectional lens) and practical ones (that empower agency and ownership for clients while also acknowledging the boundaries and rights of frontline workers).

6.5 Chapter Summary

In this chapter, I presented the participants' insights on the powerful potential of harm reduction approaches, which can allow us to reconceptualize mothers' needs and children's rights as compatible and in so doing, acknowledge the value of supporting mothers in trauma-informed ways. All of the participants point to the importance of relationship building, transparency, and reflection as part of their roles as frontline workers in harm reduction. They explain that harm reduction is the only approach that allows for trauma-informed, non-judgmental, and practical support in a way that encourages client-led healing and better outcomes for clients and their children. The following chapter discusses the different barriers that emerge from abstinence-based/harm elimination models and explains how these stem from intersectional stigma related to oppressive structures and interactions (that serve as symbolic

representations of those wider structures). Moreover, the tension between harm reduction programs and the child welfare system's approach of harm elimination are highlighted as they relate to balancing best interests for both mothers and children.

7. Identifying Barriers and Navigating Tensions

This chapter presents themes related to abstinence-based barriers as intersectional stigma (7.1), mirrored tensions between harm reduction, elimination and balancing best interests (7.2) and navigating tensions and overcoming barriers (7.3). Section 7.1 presents intersectional stigma as a barrier stemming from an abstinence-based approach before discussing the tension between such an approach and a harm reduction model in section 7.2. The ways that frontline workers navigate tensions are examined in section 7.3.

7.1 Abstinence-Based Barriers as Intersectional Stigma: *"Every One Impacts the Other"*[133]

Rather than exploring barriers in an additive sense, that is by considering them as independent difficulties that increase and 'pile' upon one another, participants conceptualize barriers as interrelated and shaped by each other. This insight is consistent with previous literature suggesting that women's experiences of barriers related to care and substance use treatment are relational (Stone, 2015; Agterberg et al., 2020). Based on Hannem's (2012) explication and in line with this project's theoretical framework, since barriers have discriminatory impacts as they act directly upon persons who hold marginal identities, they can be considered observable evidence of stigma.

The participants often use the word "stigma" to denote symbolic (interactional) stigma, which serves as a reflection of the wider forms of structural stigma and subsequent discrimination that their clients face (recall the conceptualization of symbolic stigma in chapter 3). All of them say that this kind of stigma is a barrier for their clients; moreover, they identify various structural issues that can be theorized as structural stigma. Both structural stigma,

[133] Excerpt of a quote taken from Cameron's (Participant C) interview transcript.

represented by (gaps in) policies, and symbolic stigma, evidenced in interactions, can be seen as intersectional. As Kilty (2021) notes, stigma operates at the intersection of multiple identity locations to create multiple sources of oppression whereby a layering of stigmatic attributes culminates in marginal positionalities (p. 1026). The interplay of stigma or barriers that clients face is shaped by intersections of race, socioeconomic status, health status, housing access, and identities as pregnant persons or mothers, substance users, victims of violence, and criminalized persons.

When I ask the participants about barriers, every one of them provides me with a lengthy discussion of difficulties related to intersections of these categories. Often, the barriers they discuss relate to clients' identities or stigmatic attributes that are easily visible to others (e.g. pregnancy, homelessness), thus giving them a *discredited* status according to Goffman (1963). Other times, the client may be able to keep certain identities or stigmatic attributes hidden, giving them a *discreditable* status, which leads to internalized feelings of shame, guilt, and fear of discovery/consequences upon discovery. The participants' perspectives seem to suggest that clients can be simultaneously discredited in some ways and discreditable in others—they need not belong solely to one category. The statuses of clients as *discredited, discreditable,* or combinations of both, are considered in the following discussion of abstinence-based barriers.

Based on the participants' interviews, stigma as a barrier tends to stem from a wider model of abstinence-based approaches. Abstinence-based approaches require abstinence, as the name denotes. The "black and white" (Anna), "cookie-cutter" (Cameron) nature of such approaches are the foundation for normative expectations and beliefs related to mothering and they create space for stigmatizing attributes and subsequent judgments based on notions of difference. The participants discuss multiple barriers for pregnant and mothering clients

perpetuated by Children's Services (CS), as well as the support sector more generally. Based on the interviews, abstinence or harm elimination is best understood in contrast to harm reduction. As they recount barriers in the child welfare system and social support sector, participants collectively paint a picture of how these systems are not practicing harm reduction. In other words, rather than explaining what an abstinence-based approach is, they tend to tell me what it is not. Three key features of abstinence/harm elimination approaches emerge from the interviews:

1) **They are not trauma-informed.**

   Requiring someone to abstain from substances ignores the underlying causes of substance use, which are often intertwined with trauma according to all of the participants and the literature (see Cottler et al., 1992; Covington, 2008; Torchalla et al., 2012; Barker et al., 2019). Additionally, experiences of adverse mental health, domestic violence, poverty, social isolation, and criminalization are intersectional and related to trauma, including intergenerational trauma (see Strehlau et al., 2012; Khan, 2017; Ritland et al., 2021).

2) **They are not realistic or practical.**

   By ignoring the root causes of substance use while simultaneously requiring abstinence, it is not realistic to expect that people will be able to abstain, especially when those people are stigmatized and judged. As Erin tells me, there are many reasons that people are not able to abstain from substance use, for example.

3) **They do not assign blame correctly/they misplace blame.**

   The participants point towards moral beliefs as the foundation of an abstinence-based approach. This foundation serves as the justification for judgements and stigma against pregnant persons and mothers who do not fit normative standards. They are blamed for

using substances or being in other situations that are perceived to be/may be harmful. Rather than blaming them, the participants suggest that the system should be blamed for not acknowledging the cycle of harm that it continues to perpetuate.

There are many barriers that emerge from an abstinence-based approach based on the features described above. They are discussed in the following sections, first in the context of pregnancy and the *discredited* (section 7.1.1) and second, in the context of motherhood and Children's Services (section 7.1.2).

7.1.1 The Context of Pregnancy and the Discredited

The following explanation that Cameron provides is helpful to understand the intersectional nature of stigma and the resulting barriers that emerge in everyday life for marginalized women who are pregnant; moreover, we are also able to see the disproportionate impact of changes in health protocols since the outbreak of the COVID-19 pandemic for marginalized groups:

> In these [post-COVID outbreak] times, a big barrier is medical care. They've been having to do phone appointments, which doesn't work for a lot of our clients because they don't have phones. If they do have a phone, they don't have data so they have to use a text app which requires Wi-Fi. When they're homeless, they're not really accepted into those places that have Wi-Fi available. It makes it really difficult for them to get any prenatal care.
>
> -Cameron (Participant C)

We can see how multiple barriers that limit access to prenatal care emerge from the original policy related to phone appointments. Because of their socioeconomic status and intersecting factors that contribute to a lack of housing[134], many clients are stigmatized by others in public

[134] Research has pointed to higher rates of concurrent disorders related to mental health and substance use among homeless women, which constitute risk factors for becoming homeless and for long-term homelessness (Strehlau et al., 2012).

spaces, which furthers cycles of adversity related to interconnected (and compounding) barriers and leads to distinct experiences of shame.

A *discredited* status may be more easily assigned to those who are homeless—they have no access, or limited access, to meeting basic needs related to shelter, hygiene, sustenance, and sleep; moreover, when we consider the experiences of homeless women who are pregnant and using substances, we can observe the layering impact of intersectional stigma that reproduces marginality and discrimination. Such an insight is reflected in the literature (see Strehlau et al., 2012). Furthermore, using Kilty's (2021) conceptualization of intersectional stigma as a prism, we can see how pregnancy, substance use, class, and gender each serve as a point of entry for stigma to be refracted. As we observe this prism, we are able to see how stigma becomes layered and culminates in a unique, complex, and non-summative, experience. For example, Cameron explains that staying in shelters is often the only option for clients who are homeless and pregnant, but there are many barriers that emerge from the shelter system:

> I'm gonna talk a lot about shelters today…I just experienced this the other day. Shelters have their rules and their admission criteria and they're not willing to be flexible. They say that they want to house the most vulnerable and protect them, but when our clients come and they're pregnant and using substances, there's automatic judgment. When our clients come and have behavioural issues and they're not treating staff the way they should, instead of having conversations and making a behaviour contract, they get kicked out. And that's because of the barriers in accessing mental health services right now.
>
> -Cameron (Participant C)

Cameron clearly struggles with shelters that work from an abstinence-based or harm elimination model. These shelters stigmatize clients at a structural level through policies that do not allow for any substance use whatsoever and at an interactional level by workers who carry out those policies and have justifications for their judgments towards clients.

Although they do not discuss the shelter system specifically, the other participants talk about the experience of stigma for pregnant women who use substances, as seen through the selected quotes on the following page:

> I think that one of the biggest forms of stigma is for women who are still actively using or trying to stop using and they're pregnant. As soon as you're pregnant and using, there's such a stigma against you because people think, *how can you do that to your baby*? -Demi (Participant D)

> The (pregnant and substance using) women we work with experience stigmatization and they are judged by people who do not understand how trauma manifests itself. -Erin (Participant E)

The quotes above are reminiscent of the other participants' perspectives, all of which imply that there are alternative (abstinence-based) beliefs informing and justifying the judgments and stigmatization towards both pregnant women and mothers who use substances.

7.1.2 The Context of Motherhood: Children's Services' Involvement

Unlike Alberta Health Services (AHS) which now claim to utilize harm reduction, CS is "punitive" and "black and white" (Anna). It is based on traditional models of harm elimination, not harm reduction. Based on her experience working with a program that is a joint initiative between AHS and CS, Beatrice notes the following:

> I find Children's Services to be an archaic system… They're coming from old-school protocols [and] they don't evolve a lot.
>
> -Beatrice (Participant B)

All of the participants, with the exception of Erin[135], emphasizes the difficulties of working with CS—both on a systemic level (the agency and its policies) and an interactional level (CS workers). These difficulties relate to the 'outdated' approach that Beatrice notes and that the

[135] Since Erin's interview was typed, there was less elaboration related to CS. The focus was mainly on the support that the program provides in relation to barriers at an individual level (e.g., lack of natural supports, lack of confidence), which is discussed in a later subsection (Departing Perspectives on Blame).

other participants discuss as being based on abstinence, which seems to be intertwined with systems of colonization and medicalization (TRCC, 2015a; Veenstra and Keenan, 2017; Ritland et al., 2021; Wolfson et al., 2021). In Canada, the construct of the ideal mother is based on White, middle-class, sober, and moral identities that emerge from colonial policies and are reinforced through medical regulation (Boyd, 2015). Pregnant women or people who use substances are constructed as a risk to the fetus and subsequently targeted by the child welfare system (Campbell and Herzberg, 2017). The practices of CS related to birth alerts and apprehensions serve as examples of such risk construction that leads to structural stigma and discrimination, which have significant impacts on families.

"They Just Lose Hope"[136]: Birth Alerts, Apprehensions as Structural Stigma.

Anna, Cameron, and Demi explain that historical involvement with CS (e.g., with a previous child) justifies future involvement. Indeed, up until 2019, birth alerts were a practice used across Canada, including in Alberta (Smith, 2021). A birth alert allows agencies to flag a pregnancy as high-risk and alert the child welfare agency when that baby is born (Ritland et al., 2021). If a mother had their child apprehended or assessed in the past, any future pregnancies (even years into the future) could be flagged as high-risk regardless of how her context may have changed; additionally, if pregnant people, especially those in harmful circumstances (e.g. using substances, experiencing homelessness, domestic violence, and/or adverse mental health), had any involvement with Alberta's health, criminal justice, or social services systems, which would be likely, CS would be alerted when their babies were born. Pregnant people are prioritized for opioid replacement therapy—this harm reduction strategy has been shown to decrease withdrawal symptoms, thus reducing the risk for miscarriage or other fetal harm—but

[136] Excerpt of a quote taken from Cameron's (Participant C) interview transcript.

participation in ORT also leads to surveillance and apprehensions, many of which occur because of concerns related to Neonatal Abstinence Syndrome (NAS) (Paynter, 2019).

The practice of 'birth alerts' were banned in Alberta in 2019[137], although there is a lot of damage that has already been done for mothers who are deemed "high-risk" and their children who are very likely to be apprehended (Boyd, 2019; NIMMIWG, 2019). Women who use substances, those who experience violence and poverty, and racialized women are especially vulnerable to these types of structural stigma, as some of the participants note. Anna and Cameron explains that intergenerational trauma stemming from colonization is the reason why many of their clients are Indigenous and why so many require support in multiple areas. Their perceptions are supported by literature which shows that unresolved historical trauma that Indigenous mothers face manifest through substance use, Post-Traumatic Stress Disorder, anger, family violence, and suicide—these circumstances cause them to be targeted by the child welfare system, which only reproduces cycles of harm when children are separated from their mothers (Ritland et al., 2021).

Both the Final Reports of the TRCC (2015a) and the National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIWG) (2019) highlighted the harmful and discriminatory nature of birth alerts, especially for Indigenous women and families, and called on agencies to end this practice.[138] The disproportionate impact is clear in provincial data: in 2016, Indigenous people made up only 6.5% of Alberta's population, but a majority (72%) of the

[137] In 2019, birth alerts were banned in British Columbia and Yukon Territory. Some other provinces also banned the practice in 2020 (Manitoba and Ontario) and 2021 (Prince Edward Island and Saskatchewan), although they are still practiced outside of these areas (Smith, 2021).

[138] Demi does not discuss intergenerational trauma specifically, but she does discuss barriers related to "racism" that her Indigenous clients face. Neither Beatrice (Participant B) nor Erin (Participant E) mention Indigenous people in their interviews, but in fairness to these participants, it should be noted that no interview questions were asked that referred directly to Indigenous peoples or the demographics of clients. Such an omission was intentional to refrain from conducting research directly related to Indigenous populations as a White researcher, while also considering that I had no access to statistical demographic information from programs to corroborate responses.

initial assessments conducted by CS were on Indigenous children—a trend that is consistent with previous years.[139] Birth alerts through greater levels of surveillance increase the number of initial assessments conducted, which in turn, heightens the likelihood of apprehensions (NIMMIWG, 2019). Indigenous children make up only 10% of the population in Alberta, yet they accounted for 69% of children in care in 2020 (Children's Services, 2020). The participants (Anna and Cameron) note, as does the literature, that harm elimination strategies like child apprehensions/removals are overused when women use substances and especially when women are Indigenous (see TRCC, 2015; Boyd, 2019; Caldwell and Sinha, 2020; Ritland et al., 2021).

"It Completely Crushes Them" [140]**: *Impacts of Structural Stigma.*** The participants explain that the impacts of structurally stigmatizing policies related to apprehensions are devastating for both mothers and their children. Cameron shares the following on the apprehension or removal of a child from their mother:

> It is a traumatic event, […] like a death…It's grief. Apprehensions are probably the worst visits I've ever gone on. They will often relapse, they will often go back to their abuser, they will self-harm, they'll put themselves in risky situations. I've had two clients pass away this year and I would attribute both of [their deaths] to apprehensions because they just lost hope.
>
> -Cameron (Participant C)

Cameron goes on to explain that apprehensions have "huge impacts" on children. The other participants echo this sentiment, telling me that there are "massive" (Anna) ways that child and parent separation affect attachment.

[139] 51,454 initial assessments were conducted by Alberta Children's Services in the 2016/2017 fiscal year and of those, 37,328 (72%) were on Indigenous children. The remaining 14,126 (28%) were on non-Indigenous children (Alberta Human Services, n.d.).
[140] Excerpt of a quote taken from Anna's (Participant A) interview transcript.

Beatrice shares the following insight, which is supported by literature on the impacts of parent-child separation on children (see Humphreys, 2019; Waddoups et al., 2019):

> [Apprehensions] sever the relationship… It can mean a lifetime of not attaching for that baby.
>
> -Beatrice (Participant B)

Collectively, the participants allude either directly or indirectly to the best interests of the child, explaining that children are "better off" (Beatrice) with their parents as long as their needs are being met. Such a perspective aligns with Article 19 of the *Convention on the Rights of the Child*, which specifies that children should not be separated from their parents against their will or their best interests (OHCHR, 1989). Some of the participants (Beatrice, Cameron, and Demi) also mention that there are inherent harms that emerge from the foster care system, which can be traumatic especially when they are put into multiple homes. Cameron also says that it is "usually a good thing" when children are put into kinship placements (i.e., placed with relatives or community members), although there are occasions when they are placed in environments that their mothers are a product of, thus continuing a cycle of trauma even if it goes against the wishes of the child's mother. The literature supports the participants' concerns, showing that children who grow up in foster care are more likely to struggle with criminal justice system involvement and problematic substances (Barker et al., 2014; Gypen et al., 2017). Thus, it is in this sense that harm reduction constitutes both a child rights oriented and a criminologically significant approach because it holds powerful potential to prevent further cycles of trauma and harm for children and their families today and in the future.

In order to balance the needs of both mothers and children, the participants advocate for a harm reduction approach where children can stay with their mothers as long as harm reduction strategies like safety plans are followed. According to the interviews, the current (harm

elimination) approach being used by CS creates massive barriers because the well-being of mothers is not taken into consideration and the dynamics are "authoritarian, not collaborative" (Beatrice). Cameron shares an example of a client who had her child apprehended and was only given three (3) one-hour visits per week, "and they're being watched." She questions how a mother, who already feels judged and stigmatized, is supposed to bond with her baby during that limited time. She talks about clients who have wanted to give gifts or clothing to their babies who are in foster care, but foster families have refused, which they have been allowed to do. While visitation may seem to respect the children's right to maintain personal relations and direct contact with their parent(s) on a regular basis after an apprehension or removal (CRC Article 9, subsection 3), it is clear that the operationalization of "regular basis" does not respect the best interests of the child.

Anna also discusses mothers who have pumped breast milk for their infants post-apprehension, but their breast milk is refused because of the stigma against women/mothers who use substances. Although this client was not using at the time, her past use meant that she could not be trusted in the eyes of CS. Such stories are frustrating, especially when we consider the interests of both mothers and children and the positive impacts related to bonding and connection. For example, Paynter (2019) argues for the value of breastfeeding in ensuring the best interests of the child and the parent. For the former (best interests of the child), data shows that breastmilk can reduce the severity of Neonatal Abstinence Syndrome and the need for intervention; additionally, even if the mother takes a high dose of methadone through Opioid Replacement Therapy, the infant will receive less than 0.1 mg/kg per day of methadone while breastfeeding. For the latter (best interests of the parent), she notes health benefits for the parent related to a reduction in depression as well as various diseases. Although outcomes are

determined largely by CS policies (e.g., birth alerts), participants explain that individual CS workers impact outcomes for their clients and their clients' children, in both positive and negative ways.

Individual CS workers: Symbolic Influences.[141] The participants (Anna, Demi, Beatrice, and Cameron) discuss individual CS workers in their interviews and talk about the ways in which they can and have stigmatized clients based on their own beliefs that assign blame to the mother, viewing substance use or other harmful circumstances as individual failures. Blaming the mother because of (stigmatizing) attributes that deviate from idealized standards is common within an abstinence-based system, and as the participants note, such blame is misplaced by those who do not consider contextual and historical factors (Douglas and Walsh, 2010; Boyd, 2015). CS workers do have to act according to agency policies that require intervention when children are exposed to parental substance use and violence in the home (see Chapter 5, section 5.2 in this work). However, if they hold judgments against clients based on notions of difference or deviations from the 'norm', there can be a discriminatory impact.

The influence of CS workers who stigmatize mothers based on their own judgments (according to the participants) seems to reflect the normative expectations and beliefs of an abstinence-based approach from which those judgments emerge—in other words, the influence of the worker (including their actions related to client stigmatization) serves to symbolize the structural stigma and discrimination that clients face. Additionally, the authoritarian relationship between the client and CS (where the worker can be seen as an extension or symbol of the system) creates a power dynamic whereby mothers internalize feelings of fear—fear that their

[141] The insights provided in this section are based on the participants' perspectives and as such, they are limited as they only provide one viewpoint. Future research should explore the experiences and subsequent perspectives of CS workers, as well as clients and their children, when possible, to provide a more balanced understanding that demonstrates greater inclusivity.

child(ren) could be apprehended if they are discovered as 'bad mothers' because of their substance use (past or present) or mental health struggles, for example. Anna, Beatrice, and Cameron highlight fear of CS as a common theme for their clients. These participants explain that it is an understandable response when their clients have been stigmatized and subsequently harmed in the past by CS and other agencies. It becomes apparent that the impact of symbolic (interactional) stigma persists well beyond interactions and can become internalized by the individual who may not be *discredited* in an interaction, but feels afraid that they could be, in other words, causing them to be *discreditable* (Goffman, 1963).

The literature supports the suggestion that being afraid of apprehension is a barrier to treatment, support, and healing for mothers (Jessup et al., 2003; Davies and Krane, 2006; Douglas and Walsh, 2010; Wolfson, 2021) and that this fear seems to be ever-present (Boyd, 1999). Cameron explains that she tries to counteract feelings of fear and pressure that her clients face by normalizing the mothering experiences of her clients, thereby challenging against idealized constructions of motherhood:

> We try to normalize things that they feel judged by…We have a lot of moms that are at high risk for post-partum depression, so they feel guilty that they don't feel all happy and bubbly with a brand new baby. They feel guilty that they wish the baby could go away for 24 hours… When they feel they aren't hitting the milestones that they should be—that a perfect mom would be hitting—it can lead to a lot of tension which affects their mental health. All of this affects baby and their attachment.
>
> -Cameron (Participant C)

Kilty and Dej (2012) explain that using essentialized constructions of motherhood as a means of empowering women actually creates a "fragile paradigm for success" by reinforcing a dichotomy of motherhood as being good or bad (p. 11). As Cameron clarified, a mother who is depressed or struggling with mental health does not mirror the ideal mother, who should be "happy and bubbly" according to mainstream beliefs. By talking about depression as a normal experience,

Cameron attempts to truly empower her clients. Cameron also acknowledges the importance of supporting mothers as a way of supporting children.

While stigma constitutes a harmful symbolic influence by CS workers, participants (Anna, Demi, Beatrice, and Cameron) explain that individual workers can also be positive influences for clients and their children, especially when the aforementioned fear is mediated by a trauma-informed and collaborative CS worker. As Anna says, people who work in child welfare are "probably some of the worst and best people." Based on participant perspectives and the theoretical framework accounting for structural stigma, I contend that the positive influences that CS workers have symbolize powerful forms of social work practice.

Most of the participants (Anna, Beatrice, Cameron, Demi) explain that having a 'good' CS worker can make a "world of difference" (Cameron) with regards to outcomes. When CS workers want to collaborate with the client and their other support worker(s), while also attempting to understand their circumstances in trauma-informed ways, outcomes tend to be more positive. Beatrice explains that in her experience, younger CS workers tend to be more likely to depart from dominant ways of doing CS work. While they are constrained by agency policies, the insights of the participants seem to suggest that there is some room for discretion on the part of the CS worker, although it is minimal. The most significant element that seems to have a powerful impact relates to the ways that CS workers treat and communicate with mothers. A communication style that aligns with harm reduction, which acknowledges the clients' humanity and value in a non-judgmental way, can reduce feelings of fear and increase the potential for positive outcomes.

Departing Perspectives on Blame. When I ask the participants about significant barriers in their clients' lives, all of them, except Beatrice, point to stigma. Although both Beatrice and

Erin acknowledge contextual factors at different points in their interviews, aligning them with the perspectives of the other participants, the questions surrounding barriers elicit the most significant departure from collective sentiments, especially for Beatrice. Both Beatrice and Erin highlight barriers that relate to the individual (mother) and their areas of need/deficiency related to parenting, but while Erin notes barriers related to individual factors like "lack of social skills, cognitive levels, lack of confidence, and parenting," she also identifies social barriers like the lack of resources and support. Beatrice, on the other hand, shifts her focus to the individual when I ask her what she believes the biggest barrier is for mothers. She tells me that the most significant barrier that mothers face is "lack of knowledge related to the harm" (Beatrice). When I ask for clarification, she explains that some mothers do not realize the impact that harm—and domestic violence in particular—has on children. Although she does not note it, we can speculate that perhaps mothers do not realize the impact such harm has on them either.

The departure in perspectives is fitting when we consider that Beatrice is a Registered Nurse—her training relates to the medical model and the focus of her work is on supporting vulnerable babies based on neurobiological research, which adds to a growing list of risk factors for children than can lead to abnormal development and behaviour (e.g., antisocial behaviour). Additionally, when we consider the larger role of CS in the program where Beatrice works (i.e., P2), we can see how there is a narrower focus on measuring and assessing the health of infants in a way that "maximizes safety" in the eyes of CS. While the intention of CS and neurobiological research that informs it is to protect children, many CS policies tend to manifest practically in a way that places blame on mothers by removing children from their homes, rather than considering the conditions that have led to disproportionate oppression and integrating such considerations into responses (Boyd, 1999; Douglas and Walsh, 2010; Wolfson et al., 2021).

Rather than supporting a harm reduction approach so that children can safely remain in their homes while their mothers heal without looming fear and shame when they do not meet internalized and normative standards, a medical model uses risk as a justification for harm elimination/abstinence-based approaches.

Harm reduction can allow us to acknowledge both the factors related to neurobiology and the socio-historic environment in a more productive and realistic way—domestic violence has a significant impact on children, but the way to address and reduce its impact does not lay in placing blame on the mother. Most of the participants acknowledge that if a mother engages in substance use, it can be harmful to the child, but it becomes clear that the way to prevent or address harm is not through a system that creates fear, shame, and judgment both through its policies and its workers who enforce those policies. It is not through a system that separates mothers and children, thereby "breaking" mothers (Anna) and increasing the likelihood of overdose and suicide (Ritland et al., 2021; Thumath et al., 2021) while also placing children in a potentially harmful foster care system (Gypen et al., 2017). Finally, it is also not through a system that refuses to prioritize mothers alongside their children (Marcellus, 2004).

7.2 Mirrored Tensions: Harm Reduction/Elimination and Balancing Best Interests

For Beatrice, there are tensions as she tries to work from a harm reduction model on the health side of her job as a nurse, while accepting that consequences are determined by the abstinence-based side of child welfare's policies. There is a similar tension for the other participants as well. While they all offer harm reduction-based support, they navigate the child welfare system with their clients knowing that harm reduction cannot prevent apprehensions from occurring, even if there is positive movement forward in terms of safety planning and healing from trauma. The tension between harm reduction practices and harm elimination

systems reflect the tension between mothers' plights and children's rights. Based on the interviewees' perspectives on CS, it seems that this agency sees harm reduction as a tool to be used for the benefit of the mother, not for the child.[142]

CS uses harm elimination to fulfill their mandate of child protection because removing the harm completely is ideal and even necessary to ensure that children's rights are protected. Protecting children and their rights is of significant concern, which is why we must ask: does this current (abstinence-based) approach protect children? As I attempt to answer this question through this study, it becomes apparent why frustration emerges from the participants as they navigate tensions between practicing harm reduction within a system of harm elimination—in other words, while the participants are trying to protect the best interests of both mothers and children with harm reduction, their practices are constrained by a system that intends to protect children's best interests, but not necessarily mother's best interests. Such a system does not realize that by blaming the mother without understanding her struggles, they are not necessarily eliminating harm for the child.

In the original design of this study, I wanted to explore the balance of best interests for mothers and children in harm reduction programs, but as I carried out the research, it became clear that even if harm reduction holds powerful potential for mothers and their children, that potential is limited when programs are bound within the confines of a system that utilizes an opposing (abstinence-based) approach. Such an approach is intertwined with interlocking systems of oppression that manifest in intersectional stigma for pregnant people and mothers who hold identities related to substance or alcohol use, poverty, homelessness, adverse mental

[142] While not explored in this study, it is important to evaluate if and how harm reduction is perceived and applied within a CS context. Additionally, future research should aim to question how the practical realities of CS work (i.e. the day-to-day job) impact and potentially sustain discriminatory views.

health, violent victimization, and criminalization. As the participants navigate the tensions between harm reduction and harm elimination, their collective insights seem to point towards the powerful potential of reflection, which allows them reconceptualize the dominant view of (in)compatibility between mothers' needs and children's rights.

7.3 Navigating Tensions and Overcoming Barriers: Best Practices

The respective needs of women and children are often viewed as being in opposition, which creates barriers to care (Marcellus, 2004). The perspectives captured in the interviews suggest that we must reflect upon mainstream understandings and reconceptualize mothers' needs and children's rights as compatible, despite the ways in which their incompatibilities have been operationalized in the child welfare system. By refusing to prioritize the needs of mothers alongside those of their children in trauma-informed ways, the system contributes to further perpetuation of harm and cycles of trauma for families. There is a recognition among the participants that removing children from their mothers often does not lead to positive outcomes for women or for children—such an insight is supported in literature which shows the positive outcomes of keeping mothers and children together (Abrahams et al., 2010; Nathoo et al., 2013; Paynter, 2019), as well as the harmful consequences that occur when they are separated (Mackay et al., 2020; Ritland et al., 2021; Thumath et al., 2021). Harm reduction emerges as a solution to address the discriminatory and harmful nature of an abstinence-based child welfare system and aligns with a decolonial approach to child welfare.[143] This model is "not just needles or places to

[143] Harm reduction aims to acknowledge trauma, context, and centering people in whatever ways they choose, including those that are culturally located. Such an approach seems to mirror Indigenous ways of knowing and being, as well as recommendations for alternative, decolonial child welfare systems (see Blackstock et al., 2006; Ritland et al., 2021).

shoot up […], it's a mentality […], an approach that acknowledges [that our clients' lives are] their own and they have value" (Anna).

When I ask the participants if it is difficult to use harm reduction when children are involved, some (Beatrice, Cameron, and Demi) say yes, but only in relation to practical issues of having to work with an abstinence-based CS. Cameron admits that it was difficult for her only when she began working from a harm reduction model to meet clients wherever they were at:

> It was [difficult] at the beginning. I'll be honest… I didn't know a lot about substance use… It felt a bit difficult and in my mind, I was like, *I just want you to be healthy*… I didn't know any better. Now, no. It's never hard for me. I never want to see a client suffer.
>
> -Cameron (Participant C)

While dominant moral discourses view harm reduction as controversial especially when children are involved (Watkin et al., 2003; Hathaway and Tousaw, 2008; Friend et al., 2008), the participants do not seem to view my question as having a morally disputable response. They are clear that such an approach is "the only way" to support people (Anna, Beatrice).

While the participants feel that an alternative approach to child welfare using harm reduction would remove many barriers, like the literature has suggested (see Friend et al., 2008; Marcellus et al., 2018; Foster et al., 2021), they also discuss the ways that barriers can be overcome in the current system. All of them explain that it is not often that their clients overcome barriers related to stigmatization and quality of life (finances, mental health, etc.), which therefore often results in apprehensions. When clients are allowed to keep their children (or have their children returned to them after a removal/apprehension), it is attributed to sheer will by the client, sometimes in combination with a 'good' CS worker and a trusting relationship between the client and participant. All of the participants agree that there is a direct correlation between positive outcomes and a good relationship between worker and client; in a similar sense,

Beatrice explains that in the previous program she worked for where she had more time with clients, she saw better outcomes and Cameron says that she often tries to keep client files open longer than her program (P3) mandates. When there is more time to build rapport and connection, Beatrice observes that clients are better able to express readiness for change, and both she and Cameron say that they tend to see the positive impact of more time for clients. As the participants' perspectives have demonstrated, along with relationship building, prioritizing mothers alongside their children is key to successful outcomes.

7.4 Chapter Summary

This chapter presented barriers that emerge from an abstinence-based system as forms of intersectional stigma. The impacts of stigma at both interactional and structural levels were explored, as were the tensions that arose for the interviewees related to their support work utilizing harm reduction that is constrained by CS's approach of harm elimination. The implications of these tensions in support work seem to reflect the tension between balancing the best interests of mothers and children. While the child welfare system operationalizes their interests as being incompatible, the frontline support workers interviewed for this project point to harm reduction as a set of beliefs, values, and practices—in other words, as "more than just a bag of stuff" (Anna)—that allows for a reconstruction of mothers' plights and children's rights as compatible and even complementary. Such a reconstruction, which constitutes forms of reflection and self-awareness by participants, allows them to recognize the inherent problems in the current system and suggests that harm reduction is an alternative that will enhance the best interests of both mothers and children. Best practices in harm reduction include being client-centered, showing acceptance, expressing non-judgement, and practicing transparency with clients, as well as trust-based relationships that are built between clients and providers.

8. Conclusion

> We're always gonna be there for the mother and I think if more programs worked that way, it would impact the baby. If mom is doing well, then baby is going to do well.
>
> -Cameron (Participant C)

The participant's quote above is reminiscent of this study's main findings. In order to ensure that best interests are balanced for both mothers and children, we must acknowledge the interconnections and compatibilities between both. This study asked an overarching question of "In whose best interest?" by exploring how mothers' plights and children's rights are balanced in harm reduction programs through the perspectives of frontline support workers. Based on analyses of interview data and program description, the findings of this study indicate that while harm reduction aims to protect interests of both parties, the abstinence-based child welfare system in which these programs are constrained ensures no one's best interests. Interview-based accounts underscore that reconceptualizing mothers' needs and children's rights as compatible is necessary to ensure that both of their best interests are met. Through harm reduction, mothers are centered in their own lives and their agency can be acknowledged, even in a medicalized system that blames and stigmatizes them, which results in barriers to healing and supported mothering.[144] Additionally, harm reduction seems to align with a decolonial approach that prioritizes truth-telling, acknowledgment of sociohistorical context, restoration, and relation (Blackstock et al., 2006).

Utilizing a theoretical framework that mobilizes concepts of intersectionality and structural and symbolic stigma allows for an illumination of the ways in which mothering has

[144] While this research largely explores the sociological nature of discrimination and the macro components of stigma, questions remain regarding the agency of mothers, personal responsibility, and how they resist against such systems to overcome barriers. Future research should explore these issues with greater consideration of micro elements, which can allow for a more holistic understanding.

been normalized based on idealized notions of White, middle-class, and sober identities. Mothers who face harmful circumstances that intersect with one another and stem from trauma (Strehlau et al., 2012; Khan, 2017; Barker et al., 2019) are disproportionately targeted by the child welfare system (Boyd, 2015). According to the findings in this research, Alberta Children's Services seems to stigmatize mothers at a structural level through policies and practices that construct them as risks to their children because of stigmatizing identities or attributes, which deviate from the apparent norm. These mothers and their children face interventions like apprehensions and foster care placements, which are deeply impactful and traumatizing for both (Humphreys, 2019; Waddoups et al., 2019; Ritland et al., 2021).

At an interactional level, identities related to harm (e.g., substance use, domestic violence, poverty, mental health, criminal justice involvement, etc.) cause pregnant persons and mothers to be *discredited* by Alberta Children's Services workers, which can lead to internalized feelings of shame and fear of discovery when they attempt to meet Children's Services standards by concealing certain *discreditable* attributes (Goffman, 1963). By considering the intersectional manifestations of stigma as both structural and symbolic through Foucault's macro-level and Goffman's micro-level theories, as Hannem suggests, this study illustrates a "more holistic picture" (pp. 11-12) of intersectional stigma perpetuated by Children's Services and its discriminatory impacts for marginalized mothers and children.

8.1 Contribution to Criminology, Gender and Critical Drug Studies

This study contributes to criminological literature that aims to illuminate the discriminatory and oppressive aspects inherent in notions of difference—differences that are labelled as deviant and criminal (Caputo and Hatt, 1996). By considering a gender and critical drug studies perspective, this work alerts us to the ways in which the regulation of women

intersects with the regulation of substance use and mothering (Campbell and Herzberg, 2017; Boyd, 2019). Additionally, this work expands on previous research that has utilized intersectional stigma to better understand experiences (see Bowleg, 2012; Quinn et al., 2019; Kilty, 2021). A theoretical framework that mobilizes theories of intersectional(ity and) stigma on structural and symbolic levels illuminates the discriminatory impacts of stigmatizing policies on mothers and their children and the insights gathered here can inform future research that explores the potential for resistance against systemic oppression.

The intersectional manifestations of stigma, which Kilty (2021) conceptualizes as a prism whereby stigma is refracted at multiple points of identity, allow this study to contribute to a deeper understanding of marginalization and discrimination for mothers and children in situations linked to harm. Similar to Kilty's prism metaphor, this study visualizes the theoretical framework through metaphorical (intersectional stigma) lenses[145] that allow for a holistic illumination of micro and macro level issues related to interlocking systems of oppression and criminalization at the intersections of gender, race, class, and other identities (as mothers, as substance users, as subjects of violence, etc.).

This project attempts to add to a small but growing base of literature that considers elements related to substance use, domestic violence, poverty, mental health, and criminalization as distinct, yet intersectional, identities that women may hold. It is important to explore the experiences of women who are constructed as risky because of their identities, as they belong to a marginalized group that is uniquely stigmatized and perceived as unable to be 'good' mothers. Rather than focusing on a singular issue related to substance use or domestic violence, for example, this study explores harm as a wider concept, which demonstrates an awareness of

[145] Recall Figure 1 titled, *Visualizing intersectional stigma lenses*, in Chapter 3 of this work.

concurrent issues and the complex nature of trauma, but also a deeper understanding of harm reduction as an approach and powerful alternative. Furthermore, from a preventative perspective, harm reduction constitutes a criminologically significant approach that has the potential to disrupt cycles of trauma and harm for children and their families, particularly when we consider that children who grow up in foster care are more likely to use substances and be involved in the criminal justice system (Barker et al., 2014; Gypen et al., 2017).

The participants interviewed in this study discuss their own perceptions of harm reduction as an important strategy that positively influences outcomes for mothers and their children, yet they also point to tensions in their own practices of frontline work. These areas of tension relate to providing client-centered and non-judgmental support through harm reduction while simultaneously navigating a system that punishes mothers who do not practice abstinence or arbitrary versions of it (e.g., sobriety required for a year before being considered as stable according to Anna).

By considering the participants' insights through a lens of intersectional stigma, I recognize their practices of self-awareness and reflection as they navigate tensions between harm reduction and harm elimination, which mirror tensions related to balancing best interests for mothers and children. Although a harm elimination (or abstinence-based) model attempts to prioritize children, it does so by conceptualizing mothers' needs and children's rights as incompatible—within such a system, regardless of the context or their own needs, mothers must meet a certain (idealized) standard to be considered safe in a way that aligns with their children's best interests. The participants question such a conceptualization through their harm reduction practice, where they reconstruct the needs of mothers and the rights of children as compatible to one another. They support mothers by prioritizing them, not because they believe mothers have

more value than their children, but rather, because they care deeply about the wellbeing and value of both.

8.2 Recommendations in Practice and Research

This study's findings, as well as its limitations, have theoretical and practical implications related to future directions in both research and practice. This research suggests that harm reduction is a powerful tool that can allow practitioners to work towards the best interests of both mothers and children in complementary ways. Insights from the participants interviewed for this study point to relationship-building, non-judgment, and acceptance through client-centered support as an integral part of best practices in harm reduction, which aligns with previous work related to harm reduction (see Collins et al., 2011; Nathoo et al., 2013; Nathoo et al., 2016). There are nuances in the frontline support workers' conceptualizations of success where some interviewees view abstinence as the main goal that characterizes a successful outcome, like the providers in Benoit et al.'s (2014) study who see substance use as inherently problematic; others seem to reconceptualize success separately from abstinence, similar to the those in Lee and Zerai's (2010) research. In both cases, the participants in this study aimed to affirm their clients' agency through transparency, trauma-informed practice, and trust-based support; additionally, the theoretical and analytical expansion in this work which considers how the rights of children are balanced with mothers' needs points to best practices that involve a reconceptualization of both as being compatible.

The participants' practices of frontline work through their own advocacy, transparency, and reflection (discussed in section 6.4.3) seem to be particularly important in light of the many misunderstandings that they highlight related to harm reduction and harmful circumstances like substance use and domestic violence. These misunderstandings are evident to them at both

professional and public levels and according to the participants, they are rooted in abstinence-based beliefs related to harm.

By understanding the tensions between mothers' interests and children's rights in an abstinence-based child welfare system, the participants' perspectives draw our awareness to the powerful potential for positive impacts if the compatibility between them were to be acknowledged and mobilized. Harm reduction allows us to operationalize mothers' plights and children's rights as compatible by prioritizing support for mothers in non-judgemental and client-centered ways, rather than punitive ones. By prioritizing mothers and understanding their needs in light of past and current traumas (and even the increased likelihood of future trauma), the frontline workers in this study suggest that children can be helped and protected in more effective ways.

8.2.1 Addressing Limitations: Future Directions in Research

This study contributes to literature in the areas of social work, children's rights, and criminology. However, since children's rights have been considered mainly through a feminist and intersectional lens (Minow, 1986) whereby children's rights' frameworks are largely absent, future work should consider theoretical expansions to further illustrate the complexities and debates surrounding children's rights and mothers' plights.

The limitations related to generalizability and stakeholder consultation should also be addressed in future research. While the insights of those who did participate are undeniably valuable and without them, this study would not have been possible, the small sample size of five (5) participants, as well as the differences in programs where they were employed, constitute a limitation related to generalizability. It was challenging to recruit participants during the outbreak of COVID-19 because of the impacts that the pandemic had on people's lives, both

personally and professionally. The perspectives of a larger sample of frontline workers[146] should be explored further; additionally, research should consider their experiences in more detail through personal narratives of their own lives. For example, questions related to their paths into frontline work and how their own experiences have shaped their perceptions could help us to better understand their efforts towards best practices that have the interests of all individuals in mind. Given the discussion of relationship-building, which is seen as integral to harm reduction practice, future research should expand on the dynamics of power between frontline workers and clients and the impact on the salience of the relationship, rapport building, and outcomes.

It is important that future research aim to represent the direct perspectives of mothers and children who are first voice experts with lived experience. As Mander (2010) suggests and others have demonstrated, listening to people's stories "in their own words" is an important element of ethical and empathetic qualitative research (Gervais, 2011, p. 197). Future studies should thus aim to amplify the voices of mothers who are directly impacted by the child welfare system's policies and practices in a respectful and inclusive way. Additionally, since children are deeply affected by child welfare agency decisions and harmful circumstances, their voices and their right to be heard must be considered. Conducting research *with* children rather than *about* children (Collins and Gervais, 2016) is necessary because they must be recognized as human beings with distinct experiences and the right to learn, participate, and engage in their own communities and care (OHCHR, 1989; Mayall, 2002; Gervais, 2012).[147]

[146] Given the insights that emerged related to the tensions between harm reduction and harm elimination, and the limitation of this study where the perspectives of CS workers were not captured, future research with frontline workers should encompass CS workers in order to comparatively evaluate harm reduction and harm elimination/abstinence and lead to deeper understandings.

[147] For important resources on children's inclusion in research, see Ethical Research Involving Children's ERIC) (2019) website, which can be accessed here: https://childethics.com/. See also Save the Children (2004) for a helpful "toolkit supporting children's meaningful and ethical participation in research relating to violence against children" (p. 1). The toolkit can be accessed here: http://images.savethechildren.it/f/download/Policies/st/strumenti.pdf.

This study discusses the problematic aspects of an abstinence-based system that relies on a growing base of neuroscientific research to justify strategies that attempt to eliminate harm (Boyd, 1999; Moulding, 2020). While the intentions of such research are focused on children and their rights, there is a gap related to intersectional experiences and the implications of interlocking systems of oppression that disproportionately impact pregnant persons and mothers who are racialized, criminalized, using alcohol and/or substances, in violent partnerships, homeless, etc. Future interdisciplinary research should seek to explore the long-term impacts of harm, including Fetal Alcohol Spectrum Disorder (FASD), on children in ways that recognize the intersectional and traumatic nature of mothers' experiences so that outcomes can be improved for them, and thus, for their children as well.

Much of the literature and analytical focus of this work and other existing literature also relates to mothers and their experiences by employing a critique of gendered blame (see Boyd, 2015; Miller et al., 2017; Davin, 2019; MacLeod et al., 2020); therefore, it is also relevant to explore the role of fathers within such a system (Connell, 2003; United Nations, 2008). Engaging with this topic from multiple angles and through various schools of thought and fields of study, both within and beyond criminology, can serve to enhance the analytical dimensions of our understanding, which can lead to better informed practices and policies that will positively impact families.

Whether in research or practice, there must be a focus on the well-being of both mothers and their children. Yet such a focus requires us to examine the gendered burden of parenthood placed on mothers by exploring the role of (and areas of opportunity, required support for) fathers; additionally, further exploration related to the implications for non-nuclear families (including extended families) is warranted. Although mothers and children are central in this

research, the findings here underscore the importance of wider family and community involvement; to ensure better outcomes, support must also encompass family members and other interpersonal support systems given their potential influence – both positive and negative[148] – in mothers' and children's lives. At a professional level, service providers in the social work, healthcare, and criminal justice sectors should aim to be client-centered in ways that demonstrate an awareness of historical, situational, and systemic oppression. Reducing harm in practical, realistic, and non-stigmatizing ways requires us all to understand that, as Cameron contends:

> These women aren't making these choices to put their children in harm's way. These are the circumstances that they're in because of their adverse experiences in their childhood and their trauma… I just wish that people knew that they are doing the best every day with what they've been provided… They just want to be good moms and they just need support.
>
> -Cameron (Participant C)

[148] It is important to recognize that many pregnant persons, mothers, and children do not have family members who provide positive influences in their lives for a variety of reasons (for e.g. perhaps their family has harmed them in traumatic ways or they are no longer alive or in contact with them). In these cases, relatives' influence must be acknowledged as either absent or negative, and professional care providers must offer support on how to navigate and mitigate it.

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APPENDIX A: CERTIFICATE OF ETHICS APPROVAL

29/06/2020

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-06-20-5219
Titre du projet / Project Title	In Whose Best Interest? Balancing Mothers' Plights and Children's Rights in Harm Reduction Programs: Frontline Support Workers' Perspectives
Type de projet / Project Type	Thèse de maîtrise / Master's thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	29/06/2020
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	28/06/2021

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Danika DECARLO-SLOBODNIK	Département de criminologie / Department of Criminology	Chercheur Principal / Principal Investigator
Christine GERVAIS	Département de criminologie / Department of Criminology	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

550, rue Cumberland, pièce 154 Ottawa (Ontario) K1N 6N5 Canada
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29/06/2020

Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

Le Comité d'éthique de la recherche (CÉR) de l'Université d'Ottawa, opérant conformément à l'*Énoncé de politique des Trois conseils* (2014) et toutes autres lois et tous règlements applicables, a examiné et approuvé la demande d'éthique du projet de recherche ci-nommé.

L'approbation est valide pour la durée indiquée plus haut et est sujette aux conditions énumérées dans la section intitulée "Conditions Spéciales ou Commentaires". Le formulaire « Renouvellement ou Fermeture de Projet » doit être complété quatre semaines avant la date d'échéance indiquée ci-haut afin de demander un renouvellement de cette approbation éthique ou afin de fermer le dossier.

Toutes modifications apportées au projet doivent être approuvées par le CÉR avant leur mise en place, sauf si le participant doit être retiré en raison d'un danger immédiat ou s'il s'agit d'un changement ayant trait à des éléments administratifs ou logistiques du projet. Les chercheurs doivent aviser le CÉR dans les plus brefs délais de tout changement pouvant augmenter le niveau de risque aux participants ou pouvant affecter considérablement le déroulement du projet, rapporter tout évènement imprévu ou indésirable et soumettre toute nouvelle information pouvant nuire à la conduite du projet ou à la sécurité des participants.

The University of Ottawa Research Ethics Board, which operates in accordance with the *Tri-Council Policy Statement* (2014) and other applicable laws and regulations, has examined and approved the ethics application for the above-named research project.

Ethics approval is valid for the period indicated above and is subject to the conditions listed in the section entitled "Special Conditions or Comments". The "Renewal/Project Closure" form must be completedfour weeks before the above-referenced expiry date to request a renewal of this ethics approval or closure of the file.

Any changes made to the project must be approved by the REB before being implemented, except when necessary to remove participants from immediate endangerment or when the modification(s) only pertain to administrative or logistical components of the project. Investigators must also promptly alert the REB of any changes that increase the risk to participant(s), any changes that considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project or the safety of the participant(s).

Riana MARCOTTE
Responsable d'éthique en recherche / Protocol Officer
Pour/For **Barbara GRAVES** Président(e) du/ Chair of the **Comité d'éthique de la recherche en sciences sociales et humanités / Social Sciences and Humanities Research Ethics Board**

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APPENDIX B: RECRUITMENT POSTER

ARE YOU A SOCIAL WORKER EMPLOYED WITH A HARM REDUCTION PROGRAM?

DO YOU SUPPORT MOTHERS AND/OR CHILDREN LIVING IN HARMFUL CIRCUMSTANCES?

If you answered yes to these questions, you are invited to participate in a study that aims to gain insight into the views of frontline workers who support women, children, and/or families using harm reduction strategies.

We want to hear your perspective on how the best interests of both mothers and children are considered and addressed in harm reduction programs. Your participation will contribute to a more holistic understanding of harm reduction among families.

To participate in this study, you must be:

- ✓ At least 18 years old
- ✓ Currently employed as a social support worker with a harm reduction program that serves either pregnant individuals, mothers, children, or families in [redacted]
- ✓ Willing to participate in one interview lasting approximately 1.5 hours either in-person or electronically (if social distancing restrictions remain in place, interviews will be conducted virtually or over the phone)

Participants will be selected on a first come, first served basis.

Your identity and your place of employment will be kept confidential and remain anonymous in this study funded by the Social Sciences Research Council of Canada and approved by the University of Ottawa's Research Ethics Board.

For more information or to participate, please contact Danika DeCarlo-Slobodnik (Master's Student in Criminology at the University of Ottawa): [redacted]

To protect your confidentiality, we suggest that you not use your work email when contacting us.

APPENDIX C: LETTER OF INFORMATION

uOttawa

Université d'Ottawa | University of Ottawa

Département de criminologie | Department of Criminology

120 Université, FSS14002 / 120 University, FSS14002, Ottawa, ON K1N 6N5

Letter of Information

Title of the Study:	**In Whose Best Interest? Balancing Mothers' Plights and Children's Rights in Harm Reduction Programs: Frontline Support Workers' Perspectives**
Principal Investigator:	Danika DeCarlo-Slobodnik (MA student, University of Ottawa)
Thesis Supervisor:	Dr. Christine Gervais (Associate Professor, University of Ottawa)

Invitation to Participate: You are invited to participate in this study conducted by Danika DeCarlo-Slobodnik which is funded by the Social Sciences and Humanities Research Council of Canada. This research is being completed as part of a Master's thesis project in fulfillment of program requirements for a Master of Arts in Criminology at the University of Ottawa.

Purpose of the Study: The purpose of this study is to shed light on how frontline support workers in Alberta perceive the ways in which the best interests of both mothers and children are balanced and addressed within harm reduction programs.

Eligibility: Eligible participants must be employed as social/outreach workers with programs in Calgary, Alberta that use harm reduction strategies to support mothers, families, and/or children living in harmful circumstances (for e.g. problematic substance use, domestic violence, criminal justice involvement, homelessness, and/or mental health).

Participation: Participants will be asked to complete an interview that will last approximately 1.5 hours either in person, virtually, over the phone, or electronically. Interviews will take place at a mutually agreed upon time and location (including virtual options should COVID-19 restrictions remain in place). If expenses are incurred by participants, transportation costs to and from the interview will be reimbursed to the participants, up to a maximum of $50 dollars each, if the interview takes place in person. If you are not comfortable participating in person, over the phone, or virtually, but would still like to participate, you have the option of receiving an electronic copy of the interview questions, typing your responses, and returning the password-protected document to the researcher through email or another secure mode of communication. If you wish to participate in this study, please email [redacted] it is suggested that you do not use your work email to protect your anonymity and confidentiality. Participants will be selected on a first come, first served basis.

Risks: You may experience minor emotional discomfort if and when you discuss difficult situations that have occurred during your frontline work. You have the right to refuse to answer any questions without fear of reprisal. Additionally, if you experience distress during or after the interview, mental health resources can be provided to you should you request them. Every possible effort will be made to minimize the risks associated with the interview process.

Benefits: This interview gives you an outlet to express your insights and concerns. By having this confidential platform, you can share things that you may not feel comfortable sharing with others all in an effort to work towards improvements in the support sector and for the people you are serving. Your participation will contribute to a more holistic understanding of the intersectional dynamics of women's needs and children's rights in harmful situations. By understanding how you perceive successes, challenges, and other elements, the research findings can inform best practices for upholding the rights of both mothers and children.

Confidentiality and Anonymity: Your identity and the identity of the organization with whom you are employed will not be identified in any publication or presentation. The insights that you share will be used solely for the purposes of this research. All research material (interview recordings, transcripts, emails) will be password-protected and accessible only by Danika DeCarlo-Slobodnik and Dr. Christine Gervais. Pseudonyms will be used to label interview transcripts and recordings; any names and identifying information will be stored separately from audio material, transcripts, and any other interview data.

Data Storage: Throughout the study, the interview transcripts and audio recordings will be stored on Danika DeCarlo-Slobodnik's password-protected laptop. After the study is completed, the electronic files will be stored in the same secure manner for a period of 5 years. Hardcopies of the research material will be kept in a locked cabinet in the supervisor's office at the University of Ottawa until the retention period expires, at which time these documents will be shredded. Any research documents, files, and forms will only be accessible to the research team (Danika DeCarlo-Slobodnik and Dr. Christine Gervais).

Voluntary Participation: Your participation is completely voluntary. You are under no obligation to participate. If you choose to participate, we will accommodate your schedule and availability. Additionally, should the interview be conducted in person, transportation costs to and from the interview location will be reimbursed by the researcher to a maximum of $50 dollars. If you initially choose to participate but you change your mind, as is your right, you can let the researcher know and the interview schedule will be modified accordingly. If you begin the interview, but choose to withdraw during the interview, you will be able to decide whether your responses up until that point are included in the thesis. I will respect your wishes. If you choose to withdraw after the completion of the interview, any data collected from your interview will also be withdrawn unless you agree to its use.

Information about Results: When the study is completed, you will receive a link to the finished thesis. If you would like a paper copy and/or would not like to communicate through email, I will accommodate these wishes and provide you with a paper copy as well as communicate with you through a different platform (some options include WhatsApp messaging, text message, mail, etc., as per your preference). A shorter summary of findings will also be sent to you through email or provided to you in a paper copy depending on your preference.

Continued on following page.

If you have any questions or would like more information about the study, you can contact Danika DeCarlo-Slobodnik through email: [redacted]

If you have any questions about the ethical conduct of this study, you can contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5, tel.: (613) 562-5387 or email: ethics@uottawa.ca.

Please keep this letter for your records. Thank you for your time and consideration.

Kindest regards,

Danika DeCarlo-Slobodnik

APPENDIX D: CONSENT FORM (IN-PERSON/PHONE/VIRUTAL INTERVIEW)

uOttawa

Université d'Ottawa | University of Ottawa
Département de criminologie | Department of Criminology
120 Université, FSS14002 / 120 University, FSS14002, Ottawa, ON K1N 6N5

Consent Form (Version 1)

IN-PERSON/VIRTUAL/PHONE INTERVIEW

Title of the Study: **In Whose Best Interest? Balancing Mothers' Plights and Children's Rights in Harm Reduction Programs: Frontline Support Workers' Perspectives**

Principal Investigator: **Danika DeCarlo-Slobodnik**
Phone: [redacted] | Email: [redacted]

MA student, Criminology
Faculty of Social Sciences | University of Ottawa

Thesis Supervisor: **Dr. Christine Gervais**
Phone: [redacted] | Email: [redacted]

Associate Professor, Criminology
Faculty of Social Sciences | University of Ottawa

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Danika DeCarlo-Slobodnik under the supervision of Dr. Christine Gervais. This project is funded by the Social Sciences and Humanities Research Council of Canada and is being completed as a Master's thesis in fulfillment of program requirements for a Master of Arts in Criminology at the University of Ottawa.

Purpose of the Study: The purpose of this study is to shed light on how frontline support workers in Alberta perceive the ways in which the best interests of both mothers and children are balanced and addressed within harm reduction programs.

Participation: My participation will consist of taking part in an interview that will last approximately 1.5 hours, during which I will be asked to answer various questions. The in-person interview will take place at a time and location that is convenient and safe for me. If expenses are incurred by participants, transportation costs to and from the interview will be reimbursed to the participants, up to a maximum of $50 dollars each, if the interview takes place in person. If COVID-19 restrictions remain in place or if I am not comfortable with an in-person interview, the interview can take place over the phone or virtually through a secure online platform such as Microsoft Teams, Adobe Connect, or Zoom at a day and time that is suitable for me. If the interview takes place in person, virtually, or over the phone, it will be audio recorded and I will receive a copy of the interview transcript within 60 days so that I can review and approve it or request changes if I deem them applicable.

Risks: With my participation in this study, it is possible that I may experience some emotional discomfort in relaying difficult experiences. I have received assurance from the researcher that every effort will be made to minimize these risks. If I prefer, I can choose to not answer certain questions. I will also be given a list of resources after the interview, which I can draw upon should I wish to seek mental health support.

Benefits: This interview may give me an outlet to express my insights and concerns. By having this confidential platform, I can relay my views that I may not feel comfortable sharing with others. My participation may also contribute to a more holistic understanding of the intersectional dynamics of women's needs and children's rights in harmful situations. By understanding how I perceive successes, challenges, and other elements, the research findings can inform best practices for upholding the rights of both mothers and children.

Confidentiality: I have received assurance from the researcher that my identity and my place of employment, should it be known to the researcher, will remain strictly confidential. I understand that the contents of my interview will be used only for the specified research project and that my confidentiality will be protected through the use of secure and password-protected storage and pseudonyms. Any names and identifying information will also be stored separately from audio material, transcripts, and all other interview data. It has been explained to me that if I reveal that anyone is in danger, the researcher will consult with me to determine next steps and whether there is a foreseeable risk of harm. The researcher may be legally obligated to disclose information related to imminent harm of myself or others, but I understand that I will be consulted and informed before any action is taken. In order to minimize the risk of security breaches and to help ensure my confidentiality, it is recommended that I use standard safety measures such as signing out of my account, closing my browser, and locking my screen or device when I am no longer using it/when I have sent an email to the research team. Additionally, I have been informed of the suggestion that I refrain from using my work email in communications with the research team if possible to further protect my confidentiality.

Anonymity: Anonymity will be protected in the following manner: my identity as a participant and the organization that I am employed with will not be identified in any research publication. Anonymity may not be fully guaranteed due to the use of email communication, but the researcher will take all the necessary steps to ensure that anonymity is protected to the fullest extent, including password-protecting their devices and limiting access to those devices. Pseudonyms will be used in the interview data. My interview transcript and audio recording will be filed with a code and not with my name. Only the principal investigator (Danika DeCarlo-Slobodnik) and her supervisor (Dr. Christine Gervais) will have access to the password-protected file that includes my name and the code.

Conservation of Data: Throughout the study, the password protected interview document with my responses will be stored on Danika DeCarlo-Slobodnik's password-protected laptop. After the study is completed, the electronic files will be stored in the same secure manner for a period of 5 years. Hardcopies of the research material will be kept in a locked cabinet in the supervisor's office at the University of Ottawa until the retention period expires, at which time these documents will be shredded. Any research documents, files, and forms will only be accessible to the research team (Danika DeCarlo-Slobodnik and Dr. Christine Gervais).

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will only be included in the study if I allow it; otherwise, the information will be erased. If I choose to withdraw after the completion of the interview, any data collected from my interview will also be withdrawn unless I agree to its use.

If I have any questions about the study, I may contact the researcher or her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5, Phone: (613) 562-5387, Email: ethics@uottawa.ca

PLEASE SELECT ONE OF THE FOLLOWING OPTIONS:

☐ I agree to participate in an audio-recorded interview either in person, online or over the phone.

☐ I agree to participate in an interview without audio-recording either in person, online, or over the phone.

Acceptance: I, _____ *[Name of Participant]*, agree to participate in the above research study conducted by Danika DeCarlo-Slobodnik of the Criminology Department in the Faculty of Social Sciences at the University of Ottawa, under the supervision of Dr. Christine Gervais.

Participant's signature: _____ Date: _____

In the case of verbal consent, Date and Time Obtained: _____

Researcher's signature: _____ Date: _____

There are two copies of this consent form, one of which is mine to keep for my records.

APPENDIX E: CONSENT FORM (WRITTEN INTERVIEW)

uOttawa

Université d'Ottawa | University of Ottawa
Département de criminologie | Department of Criminology
120 Université, FSS14002 / 120 University, FSS14002, Ottawa, ON K1N 6N5

Consent Form (Version 2)—WRITTEN INTERVIEW

Title of the Study: **In Whose Best Interest? Balancing Mothers' Plights and Children's Rights in Harm Reduction Programs: Frontline Support Workers' Perspectives**

Principal Investigator: **Danika DeCarlo-Slobodnik**
Phone: [redacted] | Email: [redacted]

MA student, Criminology
Faculty of Social Sciences | University of Ottawa

Thesis Supervisor: **Dr. Christine Gervais**
Phone: [redacted] | Email: [redacted]

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Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Danika DeCarlo-Slobodnik under the supervision of Dr. Christine Gervais. This project is funded by the Social Sciences and Humanities Research Council of Canada and is being completed as a Master's thesis in fulfillment of program requirements for a Master of Arts in Criminology at the University of Ottawa.

Purpose of the Study: The purpose of this study is to shed light on how frontline support workers in Alberta perceive the ways in which the best interests of both mothers and children are balanced and addressed within harm reduction programs.

Participation: My participation will consist of completing an interview-based questionnaire that has approximately forty (40) questions. The interviewer will provide me with the interview questions electronically in a password-protected document. I will type my responses to these questions and return the document to the researcher either electronically or in written format (to be delivered in person or by mail), as per my preference.

Risks: With my participation in this study, it is possible that I may experience some emotional discomfort in relaying difficult experiences. I have received assurance from the researcher that every effort will be made to minimize these risks. If I prefer, I can choose to not answer certain questions. I will also be given a list of resources after the interview, which I can draw upon should I wish to seek mental health support.

Benefits: This interview may give me an outlet to express my insights and concerns. By having this confidential platform, I can relay my views that I may not feel comfortable sharing with others. My participation may also contribute to a more holistic understanding of the intersectional dynamics of women's needs and children's rights in harmful situations. By understanding how I perceive successes, challenges, and other elements, the research findings can inform best practices for upholding the rights of both mothers and children.

Confidentiality: I have received assurance from the researcher that my identity and my place of employment, should it be known to the researcher, will remain strictly confidential. I understand that the contents of my interview will be used only for the specified research project and that my confidentiality will be protected through the use of secure and password-protected storage and pseudonyms. Any names and identifying information will also be stored separately from audio material, transcripts, and all other interview data. It has been explained to me that if I reveal that anyone is in danger, the researcher will consult with me to determine next steps and whether there is a foreseeable risk of harm. The researcher may be legally obligated to disclose information related to imminent harm of myself or others, but I understand that I will be consulted and informed before any action is taken. In order to minimize the risk of security breaches and to help ensure my confidentiality, it is recommended that I use standard safety measures such as signing out of my account, closing my browser, and locking my screen or device when I am no longer using it/when I have sent an email to the research team. Additionally, I have been informed of the suggestion that I refrain from using my work email in communications with the research team, if possible, in order to further protect my confidentiality.

Anonymity: Anonymity will be protected in the following manner: my identity as a participant and the organization that I am employed with will not be identified in any research publication. Anonymity may not be fully guaranteed due to the use of email communication, but the researcher will take all the necessary steps to ensure that anonymity is protected to the fullest extent, including password-protecting their devices and limiting access to those devices. Pseudonyms will be used in the interview data. My interview transcript and audio recording will be filed with a code and not with my name. Only the principal investigator and her supervisor will have access to the password-protected file that includes my name and the code.

Conservation of Data: Throughout the study, the password protected interview document with my responses will be stored on Danika DeCarlo-Slobodnik's password-protected laptop. After the study is completed, the electronic files will be stored in the same secure manner for a period of 5 years. Hardcopies of the research material will be kept in a locked cabinet in the supervisor's office at the University of Ottawa until the retention period expires, at which time these documents will be shredded. Any research documents, files, and forms will only be accessible to the researcher and her supervisor.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will only be included in the study if I allow it; otherwise, the information will be erased. If I choose to withdraw after the completion of the interview, any data collected from my interview will also be withdrawn unless I agree to its use.

If I have any questions about the study, I may contact the researcher or her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5, Phone: (613) 562-5387, Email: ethics@uottawa.ca

Acceptance: I, _____ *[Name of Participant]*, agree to participate in the research study as described above conducted by Danika DeCarlo-Slobodnik of the Criminology Department in the Faculty of Social Sciences at the University of Ottawa, under the supervision of Dr. Christine Gervais.

Participant's signature: _____ Date: _____

In the case of verbal consent; Date and time given: _____

Researcher's signature: _____ Date: _____

There are two copies of this consent form, one of which is mine to keep for my records.

APPENDIX F: INTERVIEW GUIDE

I. DEMOGRAPHICS

1. What pronouns do you use?
2. Can you tell me about your job and what you do?
3. What does a day at work look like for you? (e.g. visits, meetings, charting, etc.)
4. How long have you worked at this job?
5. How long have you worked in this field?
6. Can you tell me more about the program you are employed with?

   – What is the program's purpose/mandate?

   – What types of harms do you address in this program?

   – What type of support does the program aim to provide

   – How are clients referred to this program (e.g. self-referral, police referral, etc.)

II. HARM REDUCTION

7. Can you tell me what harm reduction looks like according to this program? In other words, how would the agency/organization define harm reduction?
8. How would you define harm reduction personally? Is this different than how your agency would define it?
9. What is your opinion of harm reduction? Do you think it is important? Why or why not?
10. Do you think harm reduction is accepted and used by other support organizations in this region? Why or why not?
11. Do you think harm reduction is accepted by wider society in general? Why or why not?
12. Can you tell me about the clients you support in this program?

   –How do they identify (primary type of client, secondary types, e.g. mothers, pregnant individuals, children, families)?

   –What are their needs/challenges?

III. BARRIERS

13. What barriers exist for mothers related to the harmful situations they find themselves in? [Once they have responded, follow up on barriers listed below that have not been discussed.]

14. Thank you for sharing about those barriers. Are there others related to _____?

    –Mental health

    – Financial circumstances

    –Social circumstances

    –Criminalization

    –Limited resources/insufficient supports

    –Stigma

    –Internal barriers (e.g. shame, fear of failure, etc.)

15. Which of these barriers that we have discussed seem more predominant or concerning in mother's lives and why?

16. What about these barriers in children's lives—which of these barriers seem more predominant or concerning for them and why?

17. How do you think these barriers affect children?

18. Are mothers and children in these harmful circumstances stigmatized?

19. If so, how and by whom? Can you provide any examples?

    OR

    If no, can you explain why not?

20. To what extent do children's feelings or opinions play into decisions made about them (e.g. by Children's Services)?

21. Are there ways that mothers resist against any of these barriers or push back against these challenges, and thus exhibit or exercise their own agency (even in small ways)?

    [Prompting/rephrasing if needed:]

    –How do they criticize and question the barriers that they face?

    –How are their questions/criticisms perceived by others? Are they seen as acceptable? Not acceptable?

22. How often do mothers overcome these barriers that we have discussed?

23. Can you tell me about some of the times when mothers overcame these barriers?

    a) What were the outcomes? For the mothers? For the children?

    b) Why do you think they were able to overcome these challenges?

24. Can you tell me about instances in which they were unable to overcome barriers?

    a) What were the outcomes? For the mothers? For the children?

    b) Why do you think they were unable to overcome these challenges?

IV. BALANCING BEST INTERESTS FOR BOTH MOTHERS AND CHILDREN

25. Can you think of any barriers that exist for you in supporting both mothers and children in this program? In other words, can you think of any dilemmas or challenges that you face when trying to support both mothers and children using harm reduction strategies?

26. If there are dilemmas or challenges, can you explain and elaborate on them by way of examples?

    OR

    If there are no dilemmas or challenges, why do you think there are none? [Skip to question 29 after this question.]

27. How do you balance supporting mothers and children when there are such dilemmas or challenges?

28. Based on your experience, do you think there are times when it is difficult for a mother to look after her own needs, but also fulfill those of her child's?

29. If no, why not? [Skip to question 35 after this question is answered.]

    OR

    If yes, what are the most common tensions that you believe these mothers face when trying to look after their own needs and their children's needs?

30. What are the most difficult challenges/dilemmas that mothers face in these situations of tension?

31. What does attempting to overcome these tensions or challenges look like for mothers?

32. How do you guide mothers through these dilemmas?

    a) What criteria influence the guidance you provide?

    b) Is offering this support ever difficult for you? Why or why not?

33. What harm reduction strategies, if any at all, are used in this guidance/support you provide?

34. What do harm reduction strategies in this program look like for *[check harm(s) that program aims to address]*?

    ☐ Domestic Violence

    ☐ Poverty

    ☐ Homelessness

    ☐ Social Isolation

    ☐ Criminalization

    ☐ Problematic Substance Use

    ☐ Mental Health

    ☐ Other: _____

    a) Based on your knowledge, do clients use these harm reduction strategies that you provide them with? Why do you think this is? If not, why not?

    b) How do you think these strategies affect children?

    c) Is it difficult for you to offer this type of harm reduction support when children are involved?

    d) What do you think is misunderstood about *[insert harm(s) being discussed]*? What do you wish people understood?

35. Can you tell me about any examples of positive outcomes when a mother makes a decision in which both her needs and her children's needs are met?

36. Is there anything else that you would like to share about your work/experiences with mothers and their children that could help to shed further light on balancing the best interests for both mothers and children in harm reduction programs?

V. <u>CONCLUSION OF INTERVIEW</u>

37. Do you have any questions about this study?

38. How was this interview experience for you? How are you feeling now that it is over?

39. Would you like an alternative way of communicating in the future or is email okay for you?

APPENDIX G: WEBSITE CONTENT LOCATION AND CODING SCHEME

Location of Program Content Obtained

Program (P)	Location of Content	Secondary Location of Content
P1	**Programs and Services** webpage on larger organization's website	**Program Description** via third party website related to family support for FASD
P2	**Frequently Asked Questions** pdf released by larger organization	**News Release** pdf released by larger organization
P3	**Programs and Services** webpage on larger organization's website	**Referral Form** via Programs and Services webpage on larger organization's website
P4	**About** webpage on larger organization's website	**Referral Form** via Programs and Services webpage on larger organization's website

Excerpt of Coding Scheme for Program Content

Category	Question(s)	Key words	Description
Main goal	What is the main goal of the program?	Purpose; mandate; helping to; helps; intervention; objectives; aim	The program's efforts are aimed at improving outcomes through specified interventions.
Inclusion criteria	Who is the target population? Who is the program meant to support?	Population; clients; mothers; prenatal; postnatal; perinatal; children; babies; newborns; eligibility; referral	The program exists for persons who struggle with certain issues or fall into certain groups.

Excerpt of Coding Scheme for Program Content *continued*

Inclusion criteria *(continued from above)*	What are the targeted harms? What types of situations are associated with harm?	Harm; issues; challenges; difficulties; areas of need; needs; substance use; domestic violence; isolation; health; addiction	The program addresses certain issues that are associated with harm to improve outcomes.
Service provision	What type of support is provided?	Support; services; treatment; counselling; therapy; healthcare; attachment; education; outreach; role	The program provides certain services to improve outcomes.
	Who provides support?	Team; our team; meet our team	The program utilizes certain providers who each provide a specific service.

APPENDIX H: EXCERPT OF CODING SCHEME FOR INTERVIEW TRANSCRIPTS

Broad Theme	Category	Sub-themes and Keywords
Harm	Substance use	Stages of change; when they are ready; readiness for change; relapse as part of recovery
	Domestic violence	Violent partners, violent family members, abuse
	Mental health	Depression, anxiety, postpartum depression
	Other	Concurrent harm; criminal justice system involvement, criminalization; homelessness, poverty; isolation; trauma; prenatal care; healthcare
Harm reduction (HR)	Definition	Client-led, meeting client wherever they are; non-judgment; acceptance; listening
	Role of frontline worker (in HR)	Relationship building, rapport-building, trust; transparency; empowering client to self-advocate, educating others; prioritizing client; balancing mothers and children's needs; best practices
	Experiences of frontline worker (with HR)	Perceived importance of HR, HR as the only way; boundaries
	Strategies	Safety planning; client agency
Barriers	(Overlapping) barriers	Intersecting barriers; financial barriers; stigma from public, other agencies; cycles of violence, trauma
	Child welfare system/ Children's Services (CS)	Individual workers as barriers; child welfare system (CS) as a barrier; stigma; misunderstandings of trauma; fear
	Overcoming barriers	Collaboration; 'good' CS workers; supports

EXCERPT OF CODING SCHEME FOR INTERVIEW TRANSCRIPTS *continued*

Mothers and Children	Mothering	Mothers' needs, demographics, (loss of) hope; impact of apprehensions, foster care; balancing children's needs; pressure; normal/normalization; concerns; fear; impact of stigma
	Children	Children's rights and needs, best interests; listening to children's opinions; children's voices; attachment; impact of apprehensions, foster care; impact of stigma; safety