

STIGMA IN THE CHILD WELFARE AND HEALTHCARE SYSTEMS

MEDICINE, MONITORING AND MOTHERHOOD: AN EXPLORATION OF THE  
INTERPLAY BETWEEN STIGMA AND PARADOX IN THE CHILD WELFARE AND  
HEALTHCARE SYSTEMS

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## Abstract

There are a number of processes at play within the child welfare and healthcare systems that have the potential to be othering and stigmatizing for people (Pollack, 2010; Snowden, 2003; van Ryn, 2003). For example, the surveillance and monitoring mechanisms so often inherent to child welfare and healthcare organizations have the potential to not only be very frustrating and fear-provoking for people, but also extremely marginalizing and humiliating (Browne, 2006; Krane & Davies, 2000). A great deal of the literature also speaks to how much of the language used by healthcare professionals continues to be inaccessible for many service users, and how this frequently serves as a sort of othering process, effectively pushing already vulnerable individuals further into the margins (Browne, 2007; Holm, 1993; Oleniuk, Duncan & Tempier, 2013; Perkins & Repper, 2001).

These stigmatizing practices and processes are compounded and made all the more complex when the child welfare and healthcare systems operate simultaneously in people's lives. Despite this, there appears to be limited research about the interplay of the child welfare and healthcare systems in producing stigma, in spite of how closely and recurrently these structures interact and work with one another.

For this reason, it was of interest to explore the relationship between the child welfare and healthcare systems in terms of not just the potentially stigmatizing practices existing within each system separately, but more so in regards to how troublesome and marginalizing practices within these structures are intensified when these systems are encountered in tandem.

This study investigates the interaction of stigmatizing processes and practices at play between Brant Family and Children's Services and the Brantford General Hospital. Specifically,

it explores, from the viewpoint of child welfare staff, the experiences of new mothers receiving perinatal care at this hospital, who are also clients of Brant Family and Children's Services.

This study employs a critical social work framework, coupled with elements of intersectionality and a social justice lens. An eclectic methodological approach was used, integrating tenets of critical and interpretive social science research, and a narrative approach.

Four semi-structured, face-to-face interviews were conducted with child protection staff employed at Brant Family and Children's Services. These interviews were analyzed thematically, with six major themes identified, including: the exclusion of mothers within the hospital setting, issues with Brant FACS' birth alert documentation, and the paradoxical ways in which stigma can operate in the lives of new mothers receiving care at this hospital. These themes are explored and future directions and recommendations are discussed. Suggestions are also made in terms of how these organizations can begin to address the practices at play between both systems that unfortunately, appear to harmfully impact on mothers who are involved with Brant Family and Children's Services, and receiving perinatal care at the Brantford General Hospital.

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## Introduction

This research project explores the stigmatization that new mothers who are involved with the child welfare system experience while receiving perinatal care at the Brantford General Hospital. It seeks to consider how these two very powerful systems mutually influence one another, and in what manner the relationship between these organizations impacts the experiences of new mothers receiving perinatal care at this particular hospital.

Interest in this particular topic arose from my having witnessed, by way of my role as a child protection worker for 7 years, often troubling interactions between hospital staff and a number of my clients, specifically women who had recently given birth at our local hospital. Not only have I simply observed these interactions in my role as a CAS worker, I have experienced a number of my own clients talking with me about how judged, upset and often humiliated they felt as a result of what they perceived was critical, cold and judgemental treatment towards them on the part of healthcare staff at this hospital. A number of these women expressed feeling that hospital staff's treatment of them changed particularly once their involvement with the child welfare system became known.

This research project is intended to be a starting point in exploring this practice issue. Four semi-structured interviews were conducted with child protection workers employed at Brant Family and Children's Services so as to determine whether or not other staff members identify hospital staff's treatment of and behaviour towards our clients as problematic at times. A further point of investigation was to determine what efforts, if any, child protection workers have already made to address these issues in their own interactions with their clients and staff at this hospital. The specific research questions explored are: 1. What attitudes do child protection workers perceive hospital staff to have towards women who have recently given birth and who

are also involved in the child welfare system; 2. How do child protection workers respond to hospital staff who express negative impressions towards these women.

Fook (2012) argues that a primary objective of social work practice and research is to “resist” or “unsettle” harmful dominant discourses. She states that dominant discourses often go unchallenged, and that this is where their power lies – in the fact that they are so often accepted and upheld without question or criticism (Fook, 2012). As such, one primary goal of conducting this study was to uncover, and (hopefully) begin to unsettle the harmful discourses, practices and processes at play within and between Brant Family and Children’s Services and the Brantford General Hospital that contribute to and maintain the troubling stigmatization for new mothers. It was hoped that the data gleaned from these interviews would provide added context and insight into this problem, in terms of developing an understanding of other child protection staff’s perceptions and interpretations of this issue, as well as considering what potential points of intervention might look like.

## Literature Review

### “Motherhood” versus “Mothering”

Krane and Davies (2000) state that a "...mythical Eurocentric, middle-class conception of proper mothering" exists as the dominant discourse and model in today's world. This ideal around motherhood is often formally referred to in the literature as "intensive mothering". This concept was developed by O'Reilly in the 1980's and was an unintended outcome of her critique of contemporary parenting expectations on women specifically. According to O'Reilly (1980), "intensive mothering" encompasses and promotes the following tenets: 1) children can only be properly cared for by their biological mothers; 2) mothering must be provided 24/7; 3) mothers must always put their children's needs before their own; 4) mothers must turn to experts for guidance and instruction; 5) mothers are always fully satisfied, fulfilled and composed in their role as a mother; and 6) mothers must expend excessive amounts of time, energy and money in the raising of their children.

In her influential work, Adrienne Rich (1986) speaks to the oppressive and patriarchal nature of the expectations placed upon women in their role as mothers. She makes an important distinction between "motherhood" and "mothering", specifying that motherhood is "a male-defined site of oppression", while mothering is a woman's subjective experience of raising children (O'Reilly, 2004; Rich, 1986). According to Rich (1986) motherhood is the patriarchal institution of mothering that is male-defined, male-regulated and profoundly oppressive to women. Conversely, mothering is women's own experiences of childrearing, which, minus the patriarchy, hold the potential to be very positive and empowering (O'Reilly, 2004; Rich, 1986).

Rich (1986) emphasizes two main features of patriarchal motherhood that she argues are especially harmful to women as mothers: the notion that mothering is natural to all women and

that childrearing is the sole responsibility of mothers, and the fact that the institution of motherhood assigns women the sole responsibility of parenting, but affords them no power to decide or choose the conditions under which they mother. Rich (1986) refers to this experience of motherhood as “powerless responsibility”.

Building on Rich’s theoretical distinction between motherhood and mothering, O’Reilly (2004) puts forth that motherhood operates as a male-controlled institution to confine, regulate and dominate women and their mothering. Motherhood as an institution is essentially a mode of social control exercised exclusively over women (O’Reilly, 2004).

The patriarchal principles of “natural-intensive mothering” remain the official and exclusive expectations of mothering (O’Reilly, 2004). This discourse is deeply oppressive to women as it allows for the policing of woman as mothers, and marginalizes and renders unacceptable any alternative practices of mothering (O’Reilly, 2004; Rich, 1986). The profoundly oppressive nature of this ideology is intensified for women inhabiting the more marginalized spaces in society, as the pathologization these women experience when they are unable, often for various systemic reasons, to practice intensive mothering are compounded by the stigmatizing (deviancy) discourses they often already mother under related to other forms of oppression and marginalization – poverty, being a welfare recipient and single motherhood, for example (McDonald-Harker, 2015; O’Reilly, 2004).

This ideology that equates good mothering with the patriarchal notion of “natural-intensive” mothering very much influences how women are assessed and treated by police, the courts, healthcare professionals, social workers and the general public (Minaker, 2015). To this end, Krane and Davies (2000) found that assessment of maternal behaviour by professionals

continues to be informed by prevailing constructions of mothering as being necessarily and endlessly all-encompassing, emotionally absorbing and sacrificial.

When a woman is seen as living or acting in any manner outside of the patriarchal principles of motherhood, or outside of *any* traditional feminine ideal for that matter, she is frequently diminished in the public's opinion and is habitually placed, informally and/or formally, in the very stigmatizing position of "other" (Minaker, 2015; Savarese, 2015). Subsequently, "devalued" women and mothers often become the subject of multiple means of state-sponsored and state-justified regulation, surveillance, and even discipline in some instances (Minaker 2015).

This relates well to Rich's (1986) description of motherhood as "powerless responsibility". In effect, women as mothers are made to raise their children in line with ideals and practices that they are given no power to define, and that are fundamentally based on very patriarchal concepts of how women should look, behave and act as mothers (O'Reilly, 2004; Rich, 1986). When mothers do not or cannot adhere to these principles, they are pathologized, stigmatized, monitored and in many instances, criminalized and disciplined by both the state and the general public (Minaker, 2015; O'Reilly, 2004; Rich, 1986).

As the following sections of this literature review, and thesis, will reveal, the child welfare and healthcare systems are two structures that are often responsible for contributing to what Rich (1986) refers to as the experience of "powerless responsibility" that women endure under the institution of motherhood. Both systems hold a great deal of influence in not only establishing and enforcing the dominant patriarchal views around good and appropriate mothering, but in terms of the authority they have to enduringly label certain women as deviant

or unfit, and to subsequently enact extremely oppressive and stigmatizing regulatory and exclusionary practices against these mothers.

### **Indigenous Mothering**

Traditional indigenous mothering practices stand in stark contrast to the patriarchal western ideals around motherhood described above (Simpson, 2006). Pre-European contact, indigenous women and mothers were held in extremely high esteem and afforded significant authority within their communities because of their revered and sacred ability to create and sustain life (Cull, 2006; Mzinegiizhigo-Kwe Bedard, 2006; Simpson, 2006). Rather than being seen as “...slaves...who are required to live only for others”, indigenous mothers were able to, and respected for, raising children while taking part in various other personal, communal and governance activities (Simpson, 2006, p. 28). Unlike the dominant western ideal around motherhood, traditional indigenous practices and beliefs around mothering did not assume a subservient or sacrificial role for women as mothers, but rather, afforded mothers strength and respect (Sunseri, 2006). As Sunseri (2006) states:

“an alternative to patriarchal motherhood has always existed in indigenous communities, as indigenous women have historically and continually mothered in a way that is ‘different’ from the dominant culture, and that is not only empowering for indigenous women, but is potentially empowering for all women” (p. 22).

Traditionally, indigenous mothering was a very communal activity. The care of pregnant women was considered a collective responsibility, and once born, children were often raised

jointly and fluidly by many different women in their lives (Anderson, 2006; Mzinegiizhigo-Kwe Bedard, 2006; Simpson, 2006). Home births, long-term nursing and co-sleeping were also integral aspects of traditional indigenous mothering, as was an emphasis on allowing children more freedom and independence (Anderson, 2006; Cull, 2006; Simpson, 2006). These particular elements of indigenous mothering stand in blatant contrast to dominant western constructions of what constitutes appropriate childrearing.

Under the dominant patriarchal values around pregnancy, birth and mothering, not relying on western medicine is often deemed irresponsible, and receiving assistance from others is frequently viewed as weakness or inability on a mother's part (Simpson, 2006). In western delivery rooms, there are typically limits set on the number of visitors allowed, and the prescriptive, sterile environments of modern hospitals are not at all conducive to the more fluid, communal, spiritual and intuitive birthing practices inherent to traditional indigenous ways of welcoming a baby into the world (Mzinegiizhigo-Kwe Bedard, 2006; Simpson, 2006).

Indigenous mothering practices that encourage greater freedom and autonomy for children clash with the dominant and more authoritarian approach to parenting and consequently, indigenous practices in this regard are often (wrongfully) viewed, by both the general public and the state, as being disorganized, overly permissive and in many instances, neglectful (Cull, 2006; Gosselin, 2006). The component of "intensive motherhood" as described above by O'Reilly (1980) that assumes that mothers should spend excessive amounts of money in raising their children prevails today, and is also very much in conflict with traditional indigenous ways of mothering. The privileged nature of modern western society supports the notion that mothering ability and capacity are implicitly linked to material goods (Cull, 2006). Parental competence is



frequently measured by factors such as how many recreational activities a child takes part in, the size and condition of one's home, and the number of people residing in the home (Cull, 2006).

The material and financial variables to which mothering are measured and judged against conflict with indigenous mothering practices because of traditional cultural views that place greater importance on spirituality, nature, and community, than on physical and material items (Cull, 2006; Simpson, 2006). Not only do these standards conflict with traditional indigenous ways of mothering, they are also often completely unattainable for indigenous families and mothers due to generations of abusive and ill-intentioned government practices and policies that continue to force many indigenous families and communities to live in what are essentially third world conditions (Cull, 2006; Greenwood & De Leeuw, 2006; Gosselin, 2006).

While traditional indigenous ways of mothering were holistic and empowering, and are important because of their opposition to the oppressive western motherhood ideal, indigenous woman's bodies and traditional practices around mothering have very much been negatively impacted by and implicated in the colonial agenda (Greenwood & De Leeuw, 2006). The residential school system is one stark and appalling example of how indigenous women's roles as mothers and caregivers were dislodged and damaged through state and colonial measures (Cull, 2006; Gosselin, 2006). As Mzinegiizhigo-Kew Bedard (2006) states: "colonization did much to destroy, damage and send into hiding [indigenous] women's ways of knowing about motherhood" (p. 70). Indigenous ways of mothering continue to be viewed as questionable and inferior, and indigenous mothers continue to face some of the most intense state monitoring and control because of continued colonizing policies, practices and attitudes that measure traditional indigenous mothering against the dominant standards of the "ideal, white, middle class, nuclear family" (Cull, 2006, p. 146).

This is clearly evidenced by the fact that indigenous families continue to be overrepresented within the child welfare system (Blackstock, Trocme & Bennett, 2004). In their comparative analysis of indigenous and non-indigenous families involved in the Canadian child protection system, Blackstock et al (2004) found that at every significant decision point in cases, indigenous children were overrepresented, investigations involving indigenous families were more likely to be verified, cases were more likely to be kept open to ongoing services, and indigenous children were more likely to be placed in out-of-home care arrangements.

It is an unfortunate and rather shameful irony within Canada that indigenous children continue to be placed in out-of-home care at an alarming rate because state officials deem that there are concerns present within a family, when in fact, it is the legacy of the Canadian government's destructive and discriminatory policies and practices that is responsible for continuing to force indigenous families and communities to live in what are often essentially third world conditions (Cull, 2006). It is also largely because of government actions and policies steeped in racist and colonial language and beliefs, that traditional indigenous ways of mothering continue to be viewed as suspect and inferior, and indigenous mothers continue to face some of the most severe stigmatization and state scrutiny and control. (Blackstock, Trocme & Bennett, 2004; Cull, 2006; Gosselin, 2006).

### **Conceptualizing Stigma**

Research on stigma is carried out across a variety of fields, including psychology, sociology, psychiatry, and social work (Link & Phelan, 2001). There exists a considerable amount of variability, and occasional disagreement, around the definition of this term, as well as a lack of conceptual and theoretical clarity surrounding the study of stigma (Deacon, 2006; Link & Phelan, 1999, 2001; Pescosolido & Martin, 2015). Some researchers, particularly those whose work has

focused on the perspectives and experiences of individuals within traditionally stigmatized groups, have rejected the use of the term stigma, expressing concern around the fact that it depicts individuals as primarily passive, powerless victims, overlooking the myriad ways in which people challenge and resist stigmatizing processes (Reissman, 2000). Further, many people with lived experience also reject the use of the term stigma, citing that it does not capture the severity of their experiences, preferring instead to use the word “discrimination” (Link & Phelan, 1999; Reissman, 2000)

In his foundational work on the topic of stigma, Goffman (1963) defines stigma as a “mark of social disgrace” or a perceived negative attribute that disqualifies the individual or group who bear it from full social inclusion and acceptance (p. 15). These “marks” can take various forms, however, Goffman (1963) described 3 main types: a physical deformity, an individual character flaw (mental illness, for example), and “a tribal identity” related to race, religion or ethnicity (p. 17). The author argues that individuals who embody stigmatized “marks” or attributes often develop a “spoiled identity” as a result of the judgement and exclusion they face.

While Goffman’s (1963) conceptualization of stigma remains influential, it has been criticized by some authors for focusing too much on individuals and discounting the significant role that power plays in the creation and perpetuation of stigma (Campbell & Deacon, 2006; Link & Phelan, 2001; Pescosolido & Martin, 2015). Classifying and studying stigma as principally a “mark” or “attribute” inherent to an individual shifts the focus away from the relational dimension of this phenomenon, and the important and concerning role that macro-level social and structural powers and processes play in the stigmatization of individuals (Campbell & Deacon, 2006; Leka, Siegel & Schrimshaw, 2006; Link & Phelan, 2001; Parker & Aggleton, 2003). Link and Phelan’s (1999) influential definition does a good job of capturing important components of stigma

previously developed by others – including Goffman’s (1963) seminal conceptualization of stigma – while also addressing some of the criticisms and tensions outlined above.

Link and Phelan (2001) define stigma as follows:

Stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labelled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination. Thus, we apply the term stigma when elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows them to unfold. (Link & Phelan, 1999, 2001, p. 367).

By focusing on the substantial role that social, economic, and political forces play in the creation and perpetuation of stigma, a more comprehensive understanding is created (Link & Phelan, 1999, 2001). This definition highlights the relational nature of stigma and allows for the uncovering of who has the economic, social and political power to generate and confer stereotypes and stigmatization; it focuses not only on the individual or group being stereotyped and stigmatized, but also on who is carrying out the stereotyping (Lekas et al., 2006). As Lekas et al. (2006) state: “the process of stigmatization unfolds along the lines of [both] power and powerlessness” and for this reason, a definition that includes a recognition and analysis of both is essential (p. 1166).

Similar to Link and Phelan, Deacon (2006) contends that a definition of stigma must merge both the individual and social dimensions of stigma. She states that although stigmatization is

embedded within the individual psyche, it is continuously influenced by political and institutional power and contexts (Deacon, 2006). However, Deacon (2006) is critical of Link and Phelan's conceptualization of stigma, asserting that it, and other definitions, lack analytical and theoretical clarity because they have blurred and "inflated" the term by using it to explain and encompass what are in fact distinct and unrelated processes. Specifically, Deacon (2006) points out that Link and Phelan's definition describes both the act of discrimination, *and* the subjective experience of being labelled, stigmatized and discounted (Deacon, 2006).

Deacon (2006) asserts the need to differentiate between stigma and discrimination and suggests that stigma should be understood as negative attitudes or ideologies, while discrimination should be conceptualized as negative behaviours. She states: "stigma always results in blaming, shaming and status loss for the stigmatized person or group, at least in the eyes of the stigmatizer, but it does not always have to result in discrimination to have a negative effect" (Deacon, 2006, p.421). Deacon's definition is important because it speaks to the fact that stigmatizing processes and outcomes do not have to be overtly discriminatory to be destructive and marginalizing. In fact, a great deal of stigmatization can occur in hidden and rather insidious ways (Campbell & Deacon, 2006; Pescosolido & Martin, 2015)

It was Deacon's (2006) conceptualization of stigma that was applied to the carrying out and analysis of this research project and its findings.

Regardless of which specific definition of stigma used, or which field of study research is informed by, one concept that appears consistently in parallel findings is the harmful impact this phenomenon has on the lives of those who endure it. While there is considerable variation in people's individual responses to stigma, what is recurrently unearthed across disciplines, is the overall negative impact that facing stigma has on the functioning and experiences of individuals

in traditionally marginalized and oppressed groups (Benoit, McCarthy & Jansson, 2015; Levin & Van Laar, 2006).

The impact of stigma on individuals is far-reaching. Stigma results in countless physical and emotional health issues, as well as negatively effects people's social functioning. (Benoit et al, 2015; Levin & Van Laar, 2006; Link, Cullen, Frank & Wozniak, 1987; Mason, Carlisle and Watkins, 2001). People who experience stigma often have a more limited social network; experience a compromised quality of life; are more likely to face unemployment and a lower income; and frequently experience a decreased sense of wellbeing, hope and self-esteem, as a result of being excluded and/or internalizing stigmatization (Benoit et al, 2015; Levin & Van Laar, 2006). Living under the shadow of stigma, so to speak, is also found to bring about and perpetuate physical and/or mental health struggles, while resulting in an increased reluctance to engage with services and seek help, for fear of further stigmatization (Benoit et al 2015; Goffman, 1963; Mason, Carlisle & Watkins, 2001). Experiencing stigma is also found to adversely affect identity formation and development of "sense of self", particularly in relation to personal characteristics that embody traditionally excluded or stigmatized ways of living and being (Benoit et al, 2015; Levin & Van Laar, 2006). As Goffman (1963) suggests, enduring stigma ultimately "spoils identities...disqualifying individuals from full social acceptance and reducing them from a whole [person] to a tainted, discounted one" (p. 11).

### **Stigma and the Child Welfare System**

The child welfare system is arguably one of the most criticised and condemned of the human and social service sectors. Negative criticism is levelled against the system in terms of the power it is afforded, and how this power was and continues to be inappropriately and unfairly exercised, both intentionally and unintentionally, within the private lives of families and

individuals. What is revealed continually in research on contemporary child protection work is that in spite of efforts on the part of some child welfare agencies to operate under principles of collaboration with service users, and to integrate anti-oppressive practice, the system continues to function in ways that are punitive and intrusive (Rogowski, 2015; Scourfield & Welsh, 2003; Wrennall, 2010).

Many authors describe the child welfare system simply and ultimately as a surveillance system, wherein the focus is not authentically on family and child welfare, but rather, on risk assessment and management, standardized approaches to service provision, and making decisions that will be defensible when audits are carried out (Pollack, 2010; Rogowski, 2015; Scourfield & Welsh, 2003; Wrennall, 2010). According to much of the literature, the child welfare system continues to have at its basis elements of social monitoring and control, and a preoccupation with risk, where ‘expert’ discourses and opinions are placed in a position of often unquestioned privilege and primacy, the meaningful capacities for care and safety within families are not given sufficient credit, and caregivers are continually approached as being in need of reform or repair (Rogowski, 2015; Scourfield & Welsh, 2003; Wrennall, 2010).

Wrennall (2010) is particularly critical of the child welfare system’s stigmatizing regulatory practices and goes so far as to assert that the child welfare system, under the guise of protecting children, essentially carries out investigation and surveillance where traditional policing is not able to. Wrennall (2010), drawing on the work of Davies and Leonard (1999), refers to “the panoptican strategies of power” permeating the child welfare system that “represent a belief that the poor and the excluded can only be assisted and supported if [help] is accompanied by surveillance and monitoring”; she calls attention to how stigmatizing and oppressive this

surveillance can be for families, particularly those who already face multiple other forms of marginalization and oppression (p. 7).

The continued policing or surveillance role of child welfare services, and the oppressive and stigmatizing sentiment this often results in, is not lost on service users. In their study on caregivers involved with child protection services in the United Kingdom, Scourfield and Welsh (2003) spoke to one set of parents who equated the monitoring that came along with their involvement with their local child welfare agency and the compliance expected on their part, to being on parole. The family discussed a sense of feeling ashamed because of the scrutiny they faced (Scourfield & Welsh, 2003).

Along with the stigmatizing effects of the child welfare system's regulatory and risk management processes, involvement with child protection services brings with it a rather unique form of stigmatization – the stigma associated with being viewed as, or made to feel like, a failed or unsafe parent. When child welfare services become involved with a family, individuals, typically mothers, have their identity as a “good parent” called into question (Sykes, 2011). For many, being a parent is the major foundation upon which one understands, defines and arranges their life and self-concept (Sykes, 2011). Thus, not only is this crucial and meaningful identity challenged and doubted, but a very stigmatizing identity – that of a neglectful or abusive parent – is often imposed upon individuals (Croghan & Miell, 1998; Scourfield & Welsh, 2003; Sykes, 2011).

In many instances, child welfare involvement implicitly asks clients to forfeit their positive parental identity in favour of one that centres around concepts of inadequacy, harm and abuse (Sykes, 2011). This is worrisome, not only because of the stigma and potential turmoil this causes people in terms of their self-concept and functioning, but also because this often leads to a harmful,



unproductive cycle, or self-fulfilling prophecy of sorts (Brown, 2006; Croghan & Miell, 1998 Sykes, 2011).

In their research with mothers involved in the child welfare system, Brown (2006) and Sykes (2011) observed that out of a desire to distance themselves from the stigmatizing identity of “bad parent” imposed upon them during child welfare involvement many of these women would often perform subtle acts of resistance, such as not complying with service plans, or not completing service plan tasks as quickly as requested by their worker as a means of exercising their typically limited power. While, in theory, it makes sense that these women would do what they could to resist this stigmatizing identity, in order to preserve some sense of personal agency, these forms of resistance were found to result in a harmful dynamic between the women and their workers (Brown, 2006; Sykes, 2011). In effect, these acts of opposition simply served to fulfill the harmful institutional narrative around individual risk, and the worker’s (often unfair and incomplete) assessment of these women as uncaring, resistant and/or uncooperative (Brown, 2006; Sykes, 2011).

Brown (2006) adds that this questioning or challenging of one’s parental identity is further stigmatizing because of the often public nature of this stigma. The stigma of questioning parental capacity can cause significant humiliation and shame both individually and socially, ultimately resulting in what Goffman (1963) referred to as “an overall spoiled identity” (p. 448).

The child protection system can be especially stigmatizing for women in terms of its continued tendency to hold mothers solely accountable for the actions, behaviours, health and wellbeing of their children and families (Jackson & Mannix, 2004). This process is referred to in the literature and in practice as “mother blaming” and it also describes situations wherein women are blamed and shamed for conditions and experiences beyond their control, such as living in

poverty, or experiencing domestic violence (Croghan & Miell, 1998; Jackson & Mannix, 2004). Mother blaming remains a pervasive and oppressive problem within the field of child welfare, one that often goes unnoticed because of the extent to which women as mothers are judged so incessantly and unfairly by society in general (Jackson & Mannix, 2004).

As discussed previously, under the dominant patriarchal “institution of motherhood” that Rich (1986) first described, childrearing continues to be associated with extremely high expectations of solely maternal responsibility. Similarly, certain traditional social work principles, autonomy and self-actualization for example, have resulted in individual experiences being treated as both “ahistorical and asocial”, and consequently, individual, and particularly female responsibility have become the primary focus of intervention, including within the child protection system (Croghan & Mielle, 1998; Jackson & Mannix, 2004). As Jackson and Mannix (2004) state when speaking about the child welfare system:

“as mothers, the behaviour and actions of women are subject to scrutiny in ways that men as fathers are not and these behaviours and actions are often linked to family and child welfare in ways that male activities are not...concepts of blame and liability are levelled at women as mothers from the moment of conception and this continues throughout their pregnancy and the child’s life” (p.150-151).

### **Stigma and the Healthcare System**

Medicine remains a very powerful form of knowledge in western culture. Individuals vested with the authority to practice in medical contexts possess a particular kind of power and social recognition that frequently goes unchallenged. The medical system has received repeated

criticism about its capacity to perpetuate stigma (Oleniuk, Duncan & Tempier, 2013). The use of certain language – including language used by professionals towards *and* about services users - within healthcare settings is one example of the stigmatizing processes that often flourish in medicine.

Holm (1993) asserts that the medical system represents a “radically” paternalistic structure, wherein medical professionals are “...people with autonomous power over others, based on incomprehensible and exclusive bodies of knowledge, who derive status from the power and mystique of their position” (p. 108). He criticizes the manner in which information is shared, emphasizing the often insensitive and ambiguous nature of communication by medical professionals (Holm, 1993). Furthermore, Holm (1993) calls attention to the fact that when a decision or practice is questioned by service users, this is very frequently labelled as non-compliance by healthcare staff, leaving little possibility for changing these power relations.

Building on this analysis by Holm (1993), Pryce (2000) introduces the concept of “surveillance medicine”, a concept similar to the issues of control and surveillance present within the child welfare system that were discussed above. This concept of “surveillance medicine” refers to the fact that within healthcare settings, individuals are exclusively assessed and scrutinized through the “clinical gaze” of the medical professional. This constant judgement and inspection is read as appropriate and correct professional behaviour, and any kind of resistance to this medical gaze on the part of the patient is attributed to something bad or wrong within the patient, not something inherently intrusive, humiliating or erroneous within the system (Pryce, 2000).

Browne (2007) states that healthcare professionals have particular ways of behaving, using language, and participating in social relationships that mask underlying, taken-for-granted sociopolitical agendas. She suggests that these taken-for-granted ways of engaging with patients

increase health disparities for individuals, particularly when patients embody characteristics of traditionally marginalized groups (Browne, 2007). Browne (2007) suggests that this occurs because the voices of these patients are often ignored and invalidated almost automatically due to their being cast as “the other”, and because in medical interactions, as so often in society, “the other” is automatically assumed to be incapable of having a meaningful or legitimate voice (Browne, 2007).

Perkins and Repper (2001) are also critical of the language used within the healthcare system, particularly the language used to describe service users. They suggest that much of the language used in medical settings perpetuates exclusion and can be extremely stigmatizing for people, not only in terms of their experiences within the healthcare system specifically, but also in their interactions with other agencies and service providers, who frequently assume the legitimacy of this language (Perkins & Repper, 2001).

These authors highlight how commonly individuals are referred to, or identified solely by means of their diagnosis, or presumed dysfunction within the medical field, and how, because of the almost supreme authority afforded medical professionals, the validity and longevity of these labels go unquestioned by other service providers (Perkins & Repper, 2001). The authors point out how this labelling of individuals is not only extremely dehumanizing, as it denies the existence of any other aspect of that person, but that this use of language and labelling brings with it automatic implications for the way people are treated, both within and outside of formal social and human services (Perkins & Repper, 2001). Certain terms in particular, - schizophrenic, non-compliant, and drug addict for example – bring with them ideas and biases about how individuals will behave, whether they will be “a desirable patient”, as well as subsequent implications around the type of

treatment they are seen as deserving or not deserving (Oleniuk, Duncan & Tempier, 2013; Perkins & Repper, 2001).

Related to the harmful and stigmatizing use of language within healthcare settings is the influence of a particular discourse within the medical system – the “health behaviours” discourse. According to the tenets of this discourse, poor health and disability are the result of poor decision making, while good health is purely a matter of individual agency and control (Reid & Tom, 2006). Reid and Tom (2006) state that this discourse frequently plays out in the lives of mothers in particular, due to the frequency with which they interact with the healthcare system in regards to their children’s needs. These authors go on to state that this discourse is especially harmful for mothers living in poverty, as these women have often already been “culturally branded” as being poor decision makers who lack responsibility, willpower and morality (p. 404). This particular medical discourse demonstrates how, like the child welfare system, oppressive mother blaming practices and beliefs play out for women within the healthcare system as well.

Burton-Jeangros (2011) speaks to this in her analysis of medically defined standards and their stigmatizing implications in the lives of women as mothers as early on as during their pregnancies. The author focuses on women’s experiences of monitoring and judgement while pregnant, and argues that medically defined norms of what does or does not constitute an “appropriate lifestyle” during pregnancy have become so embedded in social contexts that what has resulted is the general population often publically regulating risk for pregnant women (Burton-Jeangros, 2011). She points out how women are blamed, shamed and stigmatized, both within and outside of the healthcare system, when their behaviour is seen as veering (even minimally) from what are viewed as appropriate ways of living and being while pregnant. (Burton-Jeangros, 2011).

Similarly, Jackson and Mannix (2004) found in their work with mothers that although it was the health needs of their child that brought them to the hospital, the mothers themselves felt subject to biased and very judgemental assessment by nursing staff. Their findings revealed that mothers were repeatedly judged by nurses according to their “perceived rationality, intelligence and whether or not they [appeared] sensible” (Jackson & Mannix, 2004, p. 156). These authors state that women as mothers enter into regular and recurrent contact with healthcare providers, much more so than fathers. Throughout these interactions, mothers bump up against mother-blaming discourses that are not only stigmatizing and othering, but that are “deeply misogynistic” and embedded in biomedical ideologies “entrenched in male dominated [notions]” of health, functioning and child-rearing (Jackson & Mannix, 2004, p.154).

Young (1990) also speaks to the othering and alienation processes that pregnant women experience within the medical system, specifically obstetrical medicine. Young (1990) states that women are alienated from their pregnancy and birthing experiences for 3 primary reasons: because women’s health conditions are often defined as disorders, because medical practices and instruments diminish women’s own subjective experiences of their bodies and pregnancies, and because the social relations and power within medical settings reduce women’s control over their experiences. Similar to Jackson and Mannix, Young (1990) argues that these othering processes have their foundation in the “implicit male bias in western medicine’s conception of health” (p. 59). She states that medicine has become an institution with far-reaching authority that remains governed and controlled primarily by men (Young, 1990). Young (1990) goes on to state that the authority of the medical system is amplified for pregnant women by “the dynamic of gender hierarchy” (p.61). The power that the typically male doctor has over the knowledge of a woman’s bodily functioning, coupled with his authority to dictate the carrying out of appointments and the

actual birthing plan and experience, is often felt by women to be another form of oppressive and stigmatizing male power (Young, 1990). Reid and Tom (2006) speak to this concept as well when they liken the shame and humiliation that women experience within “exclusionary institutions” such as medicine to the “...same patterns of control and power that are often characteristic of relationships between men and women, between parents and children” (p. 403).

### **Stigma in Action: The Paradoxical Nature of Service Involvement**

A significant body of research considers the biases upheld within different human and social service environments, and the impact that service providers' perceptions have on individual service users, and the type and quality of treatment people subsequently receive (Pollack, 2010; Snowden, 2003; van Ryn, 2003). A bias related finding that struck me repeatedly is the fact that individuals whose behaviour, lifestyle and/or appearance falls outside of the dominant and more valued "norms", individuals from racialized groups, those struggling with mental health and/or substance abuse issues, members of the LGBTQ community, for example, are often less listened to during assessment and treatment planning. This is because these individuals are seen as being less likely to follow through with services or treatment because they are perceived to fall outside of assumed norms. (Pollack, 2010; Snowden, 2003; van Ryn, 2003).

At the same time, and rather ironically, these more marginalized service users often experience increased scrutiny from service providers when compared to individuals who are viewed by professionals as adhering to societal norms (Brown, 2006; Krane & Davies, 2000; Pollack, 2010; Snowden, 2003; van Ryn, 2003). Individuals who fall outside of dominant ideals of how people should look, behave, parent, live and so on, frequently fall victim to a rather harmful paradox when accessing services. They face increased scrutiny and judgment, and are often expected to readily answer questions that delve into very personal facets of their lives (and when

they are reluctant in terms of answering such questions they are habitually labelled as being "resistant" or "non-compliant" and thus, even less likely to receive adequate and needed support - this is another topic altogether, however). At the same time, their perspective, voice and experiential knowledge often go ignored in favour of what is typically considered superior or "expert" knowledge (Brown, 2006; Krane & Davies, 2000; Pollack, 2010). This is essentially one way stigma operates in people's lives. Minaker (2015) summarizes this very well when she describes how marginalized individuals are often "placed in the space of 'other', puzzlingly unseen but hyper-visible" (p. 2).

Pollack (2010) also speaks of this paradox of stigma in her study on women involved in the Canadian criminal justice system. She emphasizes how, in spite of almost constant surveillance and questioning, they are often labelled and assessed based only on the opinions of service providers. She states:

Women in this study pointed out that the correctional perspectives and categories through which their behaviour was evaluated allowed little space for the actualities of their experience. Somewhat paradoxically then, the intense scrutiny and surveillance to which criminalized women are subjected - the very visibility of their lives - actually rendered them invisible (Pollack, 2010, p. 1271).

Arguably, what is especially concerning about the paradoxical manner in which stigma can function in the lives of marginalized individuals is that when labelling and assessments are carried out by service providers, these are often incomplete, as well as extremely enduring (Pollack, 2010). Once assessed negatively by a service provider, people who embody stigmatized "marks", to use



Goffman's (1963) term, often forever become that label. They are then viewed merely as “a collection of risk factors to be managed, a profile which subsequently frames how [all] mechanisms of the state with interact with [them]” (Brown, 2006, p. 355). Once these sort of permanent evaluations are made, the surveillance, exclusion and/or discipline of stigmatized individuals by so-called “experts” becomes justified under the dominant discourses that permeate much of the social and human service systems (Brown, 2006; Jackson & Mannix, 2004; Pollack, 2010; Savarese, 2015).

The research is clear in demonstrating that the lives of women as mothers are more likely to be organized by and through various social bodies and institutions that simultaneously value (patriarchal) motherhood, while devaluing and discounting certain women as mothers (Krane & Davies, 2000; Minaker & Hogeveen, 2015). Thus, by virtue of so often being cast as the sole or primary caregiver, women are more likely to bump up against and be impacted by the stigmatizing practices inherent to the child welfare and healthcare systems. These same women are also more likely to be effected by the harmful paradoxical manner in which stigma can take shape in people's lives (Browne, 2007; Krane & Davies, 2000; Pollack, 2010).

### **Tension in Practice: “Care versus Control”**

There exists a constant tension within the field of social work – that between care and control. Margolin (1997) states that social workers practice by two significant contradictions: to help and support, but simultaneously, to investigate, monitor, and impose dominant, often privileged values on the individuals they are intended to serve and assist. Care and control practices flourish within social work as they are often framed as being essential to ensuring the safety and wellbeing of service users, as well as the general public (Tangenberg & Kemp, 2002). This contradictory practice of care versus control is particularly acute in social work practice carried

out in institutional and mandated settings, such as within hospitals, the criminal justice system and child welfare, where support is offered alongside continual monitoring to ensure client participation in, and adherence to often compulsory programs (Tangenberg & Kemp, 2002).

This contradictory dynamic is so concerning as oftentimes, the control mechanisms end up dominating practice, yet they manage to remain hidden under the continued guise of care and support (Margolin, 1997). As Greene (2006) states when talking about young mothers' involvement with human and social services, social workers habitually use their position to engage in the "policing and enforcement of 'disciplining' bodies" (p. 40).

Tangenberg and Kemp (2002) also point out how disciplinary and control mechanisms tend to dominate social work practice. These authors talk of how social workers are routinely involved with individuals who have experienced profound trauma, degradation and oppression, and argue that by virtue of certain regulatory and disciplinary practices and discourses, social work interventions often serve only to further control, label and traumatize service users (Tangenberg & Kemp, 2002). While they do not state this outright, Tangenberg and Kemp (2002) describe a sort of superficial care often provided by social workers, and argue that this type of care is the result of a lack of genuine attention on the part of practitioners to anything beyond addressing the presenting problem, and controlling its consequences (Tangenberg & Kemp, 2002). They argue that this type of superficial care functions to keep hidden the punitive control mechanisms of practice, and that this results in client bodies, bodies which are often already extremely disenfranchised, being further "...[policed], controlled and constructed according to dominant cultural paradigms and institutional expectations" (Tangenberg & Kemp, 2002, p. 14).

The tension between care and control, and the tendency for control to dominate social work practice, is not lost on service users either.

In their work with indigenous women living with HIV/AIDS, Greene et al. (2014) found that the child welfare system functioned predominantly as a force of distrust and control in the lives of these women. Participants spoke frequently of how rather than offering any type of lasting or meaningful care or support, CAS workers appeared to use these women's HIV status against them, as a means of judgement, control, and justification for making serious and devastating case decisions (i.e. the apprehension of a child) (Greene, O'Brien-Teengs, Whitebird, & Ion, 2014).

Similarly, Dumbrill (2006) found that while child protection workers may espouse beliefs that coercion and control can be separated from casework, from the perspective of parents receiving service, this is not possible. Dumbrill's (2006, 2010) work highlights the fact that child protection clients repeatedly speak of feeling policed rather than helped, and that issues around social workers using their power "over" clients, rather than with or alongside service users, remain prevalent in the field of child protection work – and arguably in most mandated social work realms.

The ever-present tension between care and control in social work becomes all the more concerning when one reflects on how overlooked this issue typically is in practice.

Margolin (1997) states that social work succeeds in keeping hidden, both intentionally and unintentionally, the many ways it is implicated in carrying out harmful and oppressive surveillance, control and disciplinary measures. The author argues that the denial and suppression of these issues is in fact more concerning and detrimental than is the actual tension around care versus control, as it is this lack of awareness, and at times outright concealment, of social work's more insidious functions that allows for the perpetuation of these problems. Margolin (1997) states that within the field of social work, this tension and its ensuing harms are often "seamless, invisible and ubiquitous" and they remain so because of a lack of critical attention within the field to the relationship between care versus control, and the myriad and detrimental ways in which social

workers are implicated in perpetuating this tension and its related issues because of a lack of “consciousness” on the part of practitioners (Margolin, 1997, p. xiii).

It was hoped that this research project would begin to fill a gap in the contemporary scholarship by analyzing and highlighting some of the ways in which stigma operates in the lives of mothers involved with both the child welfare and healthcare systems. This project takes as its focus the accounts of child protection staff who have worked with mothers receiving perinatal care at the Brantford General Hospital. It sought to explore the views and narratives of child protection staff around the ways in which stigma operationalizes in the lives of the mothers they have worked with, how both the child welfare and healthcare systems are implicated in perpetuating stigma for this population, and how these issues can begin to be addressed within and between both systems.

## **Theoretical Framework**

Epistemologically, this research is located within a critical social work perspective, while incorporating elements of social justice and intersectionality.

### **Critical Social Work Perspective**

A critical social work stance identifies and challenges the fact that the voices of the most privileged in society are typically the ones given the most weight and validity (Fook, 2003). A critical social work perspective contests this, and endeavours to develop and give voice to new ways of knowing that move beyond dominant, often taken-for-granted ideals. In terms of research in particular, critical social work seeks to challenge essentialized, positivist claims to knowledge (Fook, 2003; Stepney, 2006). Further, this perspective makes efforts to highlight the oppressive conditions that exist for so many in society, thus challenging the common practice of attributing any deviance from prescribed norms to individual failings and inadequacies (Alderson, 1998). This perspective calls for the acknowledgement and exploration of the social, political and economic structures that cause and perpetuate oppression and marginalization in people's lives (Miller & Holstein, 1993).

This perspective also has at its core the notion of social constructionism (Miller & Holstein, 1993). A social constructionist view asserts that the nature of the world is constructed and sustained by and between social processes and people's experiences and interpretations of this reality (Burr, 2003). Because of this, there exist myriad versions and understandings of the world, none of which are better than another in terms of being nearer "the truth" (Burr, 2003). As Morley (2004) states, as per a social constructionist view of the world, "...reality is understood to be a reflection of both external structures...as well as internally constructed ways of thinking" (p.299).

This theory of the world holds that social problems are therefore, never objective in nature, but rather, exist and persist by means of people's social interactions and personal understandings of their versions of knowledge and reality (Burr, 2003; Miller & Holstein, 1993). As such, social problems and phenomenon cannot be understood or addressed through objective study and data collection; rather, by making efforts to observe and understand how individuals experience and interpret their worlds and realities social problems may be understood more deeply (Burr, 2003). A pertinent theme of social constructionism is the understanding that constructions of the world inevitably promote and sustain certain patterns and ideals, while discounting others (Burr, 2003). Essentially, our constructions of the world are wrought with (often oppressive) power relations that bring with them implications for how we act in the world, as well as how we treat others (Burr, 2003).

The application of a critical social work theoretical framework to this research project is relevant and important for a number of reasons. To begin with, it allows for a more in-depth and exploratory approach by soliciting and understanding the participants' varied narratives and constructions of the problem being investigated. Further, and arguably more importantly, the use of this particular theoretical lens was essential in terms of ensuring an exploration of the larger elements and dynamics potentially contributing to the issue being studied. It ensured that the focus of the research, and any recommendations or criticisms, were not solely related to any one group of individuals, but rather, were directed towards the larger forces at play within and between the child welfare and healthcare systems, and the potentially harmful dominant constructions of women and motherhood present within these structures, that require attention and intervention.

## **Social Justice Lens**

A number of authors suggest that researchers' foremost commitment should be directed towards pushing forward principles of social justice and equality (Beresford & Evans, 1999; Boushel, 2000). According to Baker (2003), the concept of social justice refers to "an ideal condition in which all members of a society have the same basic rights, protections, opportunities, obligations and social benefits...social justice entails advocacy to confront discrimination, oppression and institutional inequities" (p. 420). The application of a social justice perspective was therefore vital in helping to uncover, unpack and hopefully challenge any unjust, marginalizing processes and dynamics potentially contributing to the practice issue being investigated. A social justice perspective was also important in terms of informing potential recommendations and future directions, as discussed later.

## **Intersectionality**

Much research has tended to essentialize categories of people (Hankivsky, Reid, Cormier, Varcoe & Clark, 2010). Research involving women has been particularly criticized for this, and for assuming that all women, irrespective of culture, age, sexual orientation, socio-economic status and so on, have experienced the same issues in the same manner and to the same extent (Hankivsky et al, 2010). What this has resulted in is the issues pertaining to, and the views and needs of certain women, particularly those in more vulnerable groups, often being excluded from much of the research (Hankivsky et al, 2010).

The concept of intersectionality, and its application to research, calls attention to the necessity of acknowledging and investigating "multiple axes of difference" within groups of people traditionally viewed, and presented in much of the mainstream literature, as being homogenous (Hankivsky et al, 2010; p. 4). Put rather simply, intersectionality is the recognition

that the overlap, or intersection of different social categories, race, sexual identity and orientation, gender, class, religion, cultural background, for example, add up to produce different experiences for individuals, and varying degrees of oppression and disadvantage (Hankivsky et al, 2010). Certain individuals – typically those who do not represent the white, heterosexual, male, middle class population – experience varying and multiple “intersections of difference” and consequently, multiple and compounded intersections of oppression, discrimination and oftentimes, victimization (Hankivsky et al, 2010; Staunaes, 2003). Intersectionality seeks to identify, understand and address “...the multiple dimensions of social inequality that manifest at both the macro-level of institutions and the micro-level of the individual experiences of [people] who live at the intersections of multiple inequalities” (Reid, Pederson & Dupere, 2007, p. 80).

Thus, while above I discuss generally the roles of women as mothers navigating the social and human service realms, there is a necessary recognition that these experiences are in fact incredibly varied, nuanced and complex, given the vast differences in terms of the lives and experiences of all women.

The application of an intersectional analysis to this project was essential as this allowed for the investigation of the overlapping stigmas that women experience as a result of the systemic inequalities and harmful dominant discourses that exist based on gender, race, class and so on. Intersectionality as a theoretical framework helped to ensure that the complex experiences of women who live at the intersection or overlap of multiple differences were adequately captured, specifically in the context of how these intersections play out during their involvement with both Brant FACS and the Brantford General Hospital. An intersectional lens further allowed for the investigation of how certain harmful discourses and practices around particular categories or intersections of difference have become harmfully woven into clinical practice with mothers



within both organizations. There is a social justice component to intersectionality in that it seeks to look for ways of “facilitating liberatory dialogue across race, class, gender and sexuality divides” (Reid, Pederson & Dupere, 2007, p. 80). For this reason as well, an intersectional analysis was meaningful in the context of this project in terms of developing recommendations around how the problem of stigma being studied can begin to be addressed by both Brant FACS and the Brantford General Hospital.

## **Methodology**

### **Methodological Approach**

An eclectic methodological approach was employed, one that incorporated elements of interpretive and critical social science research, as well as a narrative approach in the context of data collection and analysis.

#### *Interpretive Social Science Research*

An interpretive methodological approach to research involves focusing deeply on participants' accounts, definitions and meanings (Neuman, 1997). This methodology is concerned with understanding and portraying the manner in which individuals "reason, feel and see things", as well as explaining social processes and phenomena (Mason, 2002; Neuman, 1997, p. 72). Under an interpretive approach, the knowledge and perspectives of participants is considered instrumental in studying and understanding social action and reality (Neuman, 1997).

An interpretive methodology is used throughout the research process with an emphasis on the data collection and analysis processes. Efforts were made during interviews to gather participants' thoughts, feelings and opinions about their work with their clients and the hospital. A number of the research questions were developed to garner information around what participants believed to be occurring in the situation being studied, how they defined what is taking place within and behind the troubling hospital situation, and what they hold to be relevant to this issue, and to any efforts made to address this issue.

This methodology was also applied to data analysis in the sense that the data was not simply read and reported at face-value, but rather, was analyzed for any unspoken interpretations and understandings of the participants' experiences. As Mason (2002) puts forth, analyzing data

through an interpretive lens means the researcher will be “involved in reading through or beyond the data in some way...” (p. 149).

### *Critical Social Science Research*

I will admit to having one fairly significant critique of interpretive social science research; that is, it lacks any kind of structural or transformative focus. For this reason, it was very important to include a critical social science methodology. Critical researchers seek to conduct research that critiques and transforms social conditions and relations (Neuman, 1997). These researchers are unhappy with a current situation and by means of their research, endeavour to bring shed light on the hidden, oppressive and often conflict-filled forces at play in society (Neuman, 1997). Critical social science research should have an emancipatory aim; research is meant to empower people, raise their awareness to troubling, oppressive (and often hidden) structures and mechanisms in society, and ultimately, serve as a catalyst to confront and change these things (Neuman, 1997). In this way, critical research has “an activist orientation” and there is the belief within this methodology that researchers have an obligation to take their research beyond their study and its write-up, and act on any findings and recommendations in meaningful, tangible ways (Neuman, 1997). As Neuman (1997) states, “the researcher who studies trivial behaviour, who fails to probe beneath the surface, or who buries the results in a university library is making a moral choice...[that choice] is to take information from the people being studied without involving them or liberating them” (p. 79).

This framework is reflected in my methodology most apparently in the data collection and analysis sections of this study. Certain interview questions were intended to gain a sense of structural issues, and possible interventions or points of change participants felt were relevant or necessary. In terms of data analysis, the application of a critical lens was extremely helpful and

interesting. Efforts were made to elicit information and themes around the larger structural powers that may have been operating within people's experiences and narratives, as well as to consider how any larger, systemic forces influence the practice problem being studied (Mason, 2002; Neuman, 1997).

### **Ethical Considerations**

Ethics approval was obtained from the McMaster University Research Ethics Board (REB). One significant ethical consideration that is important to note here is the fact that while completing the research interviews, I was not only acting as a researcher, but was a co-worker of the participants. This potential ethical tension was addressed, and ultimately approved by the REB, by means of my assurance that it would be made clear to participants, in both the recruitment email and Letter of Information that participation was completely voluntary and that choosing not to participate, or choosing to withdraw, would in no way affect people's relationships with Brant FACS or McMaster's School of Social Work.

Additionally, recruitment emails were sent out on my behalf by Brant FACS' quality assurance manager; this was to ensure that any sense of coercion or pressure was removed for staff. Lastly, staff from my direct team at Brant FACS were not included when the recruitment email was distributed within the agency. This helped to ensure that I did not have an overly close working relationship with any of the participants, or that individuals with whom I work directly, did not feel any pressure to take part in this study because of our close working relationship.

### **Participants**

Participants were required to have some past or current experience in intake and/or ongoing service positions at the agency. This was to ensure that participants had experience working with women in a child protection capacity of some sort, and were therefore likely to have worked with

women who had received care at the Brantford General Hospital. There were no other restrictions or recruitment criteria in place.

In total, four participants were interviewed. All four of the participants were employees at Brant Family and Children's Services (Brant FACS) at the time of the interviews. Participants' length of employment ranged from just under 2 years to 15 years. Two participants were child protection workers on the agency's First Nations First Response Team, which is a team that services First Nations clients living off reserve. Of the two participants from this team, one worker was white, while the other was indigenous and from the same band (Six Nations) as a number of her clients.

Another participant was a Family Service Worker on a community-based child protection team, and the fourth participant was a manager. Three of the participants had current intake and/or ongoing service experience; the manager who participated had extensive experience in both intake and ongoing service positions when she was a frontline worker. No other demographic information was collected as it was not felt that this was relevant to this particular study.

## **Recruitment**

Participants were recruited via an email recruitment letter (Appendix A), which was sent on my behalf by Brant FACS' Quality Assurance Manager to all child protection teams, with the exception of the team that I work on directly. A copy of the Letter of Information/Consent Form (Appendix B) was attached to the email for individuals to review. Interested individuals were directed to email me directly.

Upon hearing from potential participants, any questions they raised were answered and a date, time and convenient location were arranged for the interview. All four interviews took place in an office or private meeting room at one of Brant FACS' buildings.

## **Data Collection**

Data was collected by means of semi-structured face-to-face interviews. Interviews began with me explaining the study, Letter of Information and consent form, and providing participants with the time to ask any questions, and review and sign the Letter of Information and consent form. Participants were provided with copies of the Letter of Information and their signed consent form for reference if they wished. The originals were kept in a private, locked filing cabinet in my home. With the participants' permission, all four interviews were audio-recorded on my personal password-protected cellular phone. Handwritten notes were completed during interviews as needed. Interviews ranged in length from approximately 30 minutes to approximately 55 minutes. At the completion of the interviews, participants received a small token of appreciation in the form of a gift card.

The interviews were semi-structured in nature and were intended to be exploratory, with the Interview Guide (Appendix C) being developed using elements of a narrative approach. Questions were open-ended and written in simple language so as to allow for the participants to share their answers freely and flexibly.

The content of the interview questions centred around participants' work experiences at Brant FACS, particularly in terms of their experiences with, and opinions and feelings around working with clients (mothers in particular) who had received perinatal care on Brantford General Hospital's labour and delivery and/or maternity wards. Questions also attempted to explore participants' thoughts and experiences around their own working relationships with hospital staff, as well as their feelings in regards to Brant FACS' overall partnership with this hospital. Attempts were made via certain interview questions to garner information about possible systemic and

structural factors at play and influencing participants' experiences and opinions, as well as ways in which participants felt any identified issues could begin to be addressed by both organizations.

## **Data Analysis**

### *Narrative Analysis*

A narrative approach was applied to data collection and analysis, in terms of the interviews taking a more conversational and less structured tone; interview questions were also intended to gather more in-depth accounts from participants about their specific experiences in relation to the topic of study (Bell, 2002; Squire, Andrews & Tamboukou, 2013; Squire, 2013). Because narrative analysis is “slow and painstaking, requiring attention to subtlety” it is not an appropriate means of analysis for the study of large numbers of “nameless, faceless subjects” (Riessman, 2001, p. 692). The small number of participants (four) in this study made the inclusion of a narrative approach accessible and realistic.

Narrative researchers operate from the belief that narratives function in opposition to much of the exclusive scholarly discourses that exist and which are so influential in society, particularly within research and academic settings (Bell, 2002; Riessman, 2001, 2008). A narrative approach to research, in its most complete sense, involves soliciting detailed and comprehensive accounts from participants about their experiences, and analyzing the embedded assumptions and beliefs that the narratives illustrate (Bell, 2002). This allows researchers to present data holistically, enabling us access to diverse ways of seeing (Bell, 2002). As Squire et al (2013) state, “narratives carry traces of human lives that we want to understand” (p. 3).

Riessman (2001, 2008) talks a great deal about the validity and benefits of applying a narrative approach to research. The author states that narrative analysis takes as its point of investigation the story itself, and that this type of analysis is not only appropriate for the study of

personal experiences, but can be applied to research relating to political change, social movements and macro-level issues and occurrences as well (Riessman, 2001, 2008). Referencing Laslett (1999), Riessman states: "...the analysis of personal narratives can illuminate individual and collective action and meanings, as well as the processes by which social life and human relationships are made and changed" (Riessman, 2001, 698).

Riessman (2001) is also clear that her approach to narrative analysis is not objective in nature, but rather, assumes positionality and subjectivity. As the author states, "...the perspectives of both narrator and analyst can come into view" (Riessman, 2001, p. 695).

In this way, narrative analysis lends well to social constructionism, which is an element of the critical social work theoretical framework also applied to this research project. As Riessman (2001) states: "...the verification of 'facts' of lives and experiences is less salient than understanding the changing meaning of events for the individuals involved and how these, in turn, are located in history and culture" (p. 691).

As with all methodologies, there are many forms of narrative research (Riessman, 2001, 2008). The application of this framework to this particular study was intended to allow as much space as possible for the most comprehensive and individual accounts and beliefs about the situation being studied to be solicited and discussed.

Riessman (2008) identifies two primary forms of narrative analysis - thematic and structural analysis. A structural analysis focuses on the telling of a narrative - the *way* a story is told (Riessman, 2008). Thematic analysis emphasizes the content of the text, or "...*what* is said more than how it is said" (Riessman, 2008, p.55). A thematic approach is helpful for theorizing across a number of cases, and for uncovering common thematic elements throughout the narratives shared by research participants (Riessman, 2008).



Thematic narrative analysis, as described by Riessman (2008) was applied to data analysis for this project. While there were multiple interview questions and these were laid out ahead of time in an interview guide, the application of this guide was still done flexibly throughout the interviews so as to allow participants to share as freely as possible. As participants shared their narratives, I listened closely, asking for clarification when needed. Once interviews were completed, they were transcribed verbatim by myself. The approach to narrative analysis applied to this project mirrors Riessman's (2008) process of thematic narrative analysis which involves the unpacking, interpretation and analysis of interview narratives. The interview data was read both literally and interpretively for content and common thematic elements across participants' narratives. The reading of interviews was done a number of times, alongside extensive note-taking. This was done so as to ensure as best as possible that the narratives, and any potential common themes, were interpreted accurately, and as comprehensively as possible.

### **The Nature of and Need for Risk Assessment: A Disclaimer**

I think it is important for me to briefly state at this point, as a disclaimer of sorts, that this study is not at all intended to be an argument against upholding standards and values around what constitutes safe and appropriate parenting. I am also not trying to suggest that professionals assessing for risk as it relates to children is not necessary, as it most definitely is in some instances. As Krane and Davies (2000) state, "of course social workers have to assess for risk and they need means to identify risk, but this can't be done through a filter of cultural, class and gendered assumptions" (p. 42).

It is the manner in which risk is assessed so automatically in regards to certain individuals, knowledge is handed down and subsequent stigmatizing judgments are made by service providers that is problematic at times, as the findings of this study will demonstrate below. I also think it is

essential to emphasize here that I recognize that by virtue of my role as a child protection worker, I have undoubtedly (and unfortunately) played a part, at one time or another, in some of the harmful dynamics contributing to the hospital problem described earlier that prompted my interest in this particular research topic.

## **Findings and Discussion**

### **Findings from the Interviews**

All four of the interviews conducted provided meaningful and very important insight into the topic being studied. While these interviews were rich with unique and varied opinions and ideas, by way of the analysis described above, six specific themes were identified: frequent reporting of non-child protection concerns by hospital staff; exclusion of mothers within the hospital setting; the paradoxical ways in which stigma can operate; concern from CAS staff around addressing any issues for fear of disrupting partnerships; issues with Brant FACS' birth alert document; and the presence of intersectional or overlapping stigmas, specifically in terms of race and age.

While the themes of this study are discussed below as separate and distinct, in reality, they overlap and are quite entwined in terms of their cause and impact. As such, the literature related to these themes is discussed jointly at the end of this section.

### **Reporting Non-Child Protection Concerns**

All of the study participants talked of their interactions with hospital staff on the labour and delivery and maternity wards occurring most commonly as a result of hospital staff making a referral to Brant FACS, reporting a concern in regards to a family already working with Brant FACS, and/or contacting Brant FACS for support and questions around discharge planning with a family.

One major theme that emerged out of all four interviews was the trend of hospital staff contacting Brant FACS to report non-child protection concerns. All of the participants spoke to the fact that a lack of knowledge or clarity could be the source of some of these reports; as one

participant stated, "...[hospital staff] don't always seem to understand what we do and what is a risk to babies and children and what isn't".

However, the participants did express feeling that these reports to Brant FACS were more often likely the result of hospital staff's values around mothering. Participants expressed feeling that this was the case because many reports from hospital staff appeared to be based more on disagreement around certain mothering practices, or the living situations and experiences of certain mothers, rather than on genuine child safety and wellbeing concerns.

Three of the participants provided examples of how a new mothers' young age alone has been reported to Brant FACS by nursing staff as a child protection concern. As one participant stated,

"...some staff when they call in, maybe because of their values, they look at a young mom automatically as a concern and this isn't necessarily in and of itself a concern, but staff often see young age immediately as a child protection issue".

Another participant spoke of how a mother's decision to not breastfeed had been reported to Brant FACS by hospital staff as a child protection issue, in spite of the fact that the infant was still being formula-fed properly and regularly. This participant spoke of her frustration around how strongly breastfeeding is promoted and pushed within this hospital. She talked of how problematic and stigmatizing this discourse becomes when a mother is unable to nurse, or makes a decision, for whatever personal reason, to not breastfeed, and this is subsequently viewed by hospital staff as being a child protection matter. This participant further advised of how one

hospital staff member had referred to a mother she was working with who had decided not to breastfeed as being “resistant” because of her decision in this regard.

Another participant, one of the workers from the agency’s First Nations First Response team provided a fairly stark example of non-child protection matters being reported to Brant FACS as concerns. This participant explained that she was working with an indigenous mother who had recently given birth and for medical reasons, her baby had to remain in the special care nursery. This mother, in order to visit her infant more frequently and easily, had decided to remain in the hospital overnight, in spite of having been discharged herself. Because there were apparently no beds available at the time, this woman slept in a chair all night at the hospital and staff subsequently contacted this woman’s Brant FACS worker (this participant) to report this mother’s decision to sleep at the hospital overnight as a concern.

This same participant further advised that she received another call from hospital staff in regards to this same mother reporting concerns over the fact that she and her sixteen year old daughter had walked home (because they did not have a vehicle and could not easily afford a cab) at 2am after visiting the baby. Hospital staff had expressed to this participant that they felt this was inappropriate and that it warranted a report being made to Brant FACS. This participant expressed significant frustration over having received these calls and attributed such reports to there being little to no recognition on the part of hospital staff that this mother was making repeated and continual efforts to visit and care for her new baby while he remained in the hospital, in spite of a number of systemic barriers that she was faced with (i.e. limited resources in the hospital in terms of this mother not being afforded a bed while staying to visit her new baby; poverty in terms of her not being able to easily afford transportation to and from the hospital). This participant also attributed the constant and severe criticism this mother seemed to

face from hospital staff to the fact that she was indigenous. This participant was quite clear in feeling that colonial and racist attitudes in regards to indigenous mothers persist within this hospital and that these discourses result in staff continually and automatically viewing indigenous women as being “suspect” or “less than”.

Similarly, another participant spoke of how she had received a call from a nurse reporting concern over the fact that a mother, who had been discharged herself, but whose baby also had to remain in the special care nursery for a period of time (again, there had apparently been no beds available for this woman to stay in the hospital), had called the hospital at 3am to check in on her baby; the nurse had expressed to this participant that she hadn't felt this was an appropriate time for this woman to have been calling the hospital, in spite of the fact that her reason for calling had been to check in on her baby, something that this participant expressed feeling was a very positive effort on this mother's part.

These narratives highlight the concept described earlier of how when mothers do not, or cannot, adhere to the dominant (patriarchal) ideals around motherhood they are habitually cast as an “other”, and often become viewed primarily as a collection of risk factors to be monitored (Krane & Davies, 2006; Pollack, 2010). When this occurs, any behaviour on the part of mothers viewed in this manner becomes interpreted by others as being “bad” or “illegitimate” (Krane & Davies, 2006; Pollack, 2010). This process of judging and subsequently treating certain mothers in this way appears to be pervasive within this hospital. Participants spoke of feeling that certain mothers they have worked with were viewed solely and enduringly by hospital staff as lacking or unsafe, regardless of any strengths they may have possessed, or any efforts they were making to address concerns and be present to care for their new baby. The participants working with indigenous women were clear in voicing that the issues around hospital staff reporting non-child

protection concerns were exacerbated when a mother they worked with identified as being indigenous. These participants spoke of feeling that the indigenous mothers they have worked who have received perinatal care at this hospital often seem to unjustifiably be labelled “risky” or “aggressive” by staff and subsequently, have many more reports made against them over matters that are by no means child protection issues; matters that these participants felt would not have been reported to Brant FACS, had these mothers not been indigenous. Their narratives exemplify Cull’s (2006) assertion that “indigenous mothers [live] in a society that essentially makes...indigenous identity a risk factor” (p. 151).

### **Exclusion of Mothers within the Hospital Setting**

A second theme that emerged from the interviews was the exclusion of mothers from their infants’ care. A couple of participants described situations they had experienced with families they were working with wherein the baby, because of protection concerns, was not being discharged home to mom and instead, was to be placed with a kin or foster family. These participants described witnessing hospital staff excluding the biological mother from discussions and instead, directing all of their work and conversations about these infants to the kin or foster parents, in spite of the fact that the mother was still present at the hospital.

Another participant discussed how instead of trying to encourage a new mother’s involvement in and confidence around her baby’s care, a nurse criticized this mother for the type of questions she was asking about her infant. As this participant described:

“... [the nurse] said to me that this mom’s questions were not appropriate, but I thought good for her, good for this mom for trying to learn and be involved. She was a young, new mom trying her best”.

A number of the participants described having witnessed hasty, impersonal interactions between hospital staff and their clients on many occasions. They spoke of how these interactions seemed to cause a sense of isolation for many of the women they worked with, particularly the younger moms for whom raising an infant was a new and unknown experience. As one participant stated when speaking about a young mom she was working with:

“...I know it’s not [the nurses’] job to social work through issues with families but don’t make it harder by ignoring these moms and not engaging with them really, or answering their questions about their babies...”

Certain mothers’ exclusion from their infants’ care also seemed to arise in a less direct manner in terms of some mothers admitting to their CAS worker that they felt uncomfortable asking questions of hospital staff. A number of participants talked of having had new mothers they were working with admit to feeling this way because of how they felt they were treated by hospital staff. As one participant stated:

“...moms I’ve worked with have talked about how uncomfortable they are, how upset they are for feeling like staff are not helpful or are rude. Some of these moms have told me they were afraid to ask questions about their baby because of this”.



These narratives reveal that within the Brantford General Hospital there are practices at play that preclude or “alienate” certain mothers from fully experiencing and participating in the care of their infants following birth. These stigmatizing exclusionary practices operate quite overtly in terms of hospital staff not involving certain women in the care of their babies, particularly in situations wherein the baby was being placed in a kin or foster home upon discharge. Participants described that in these instances, the focus of hospital staff’s discussions and recommendations were almost exclusively directed towards the alternative caregivers. What is concerning is that this exclusion occurred in spite of the fact that these mothers were still present in the hospital and as such, according to the participants who described these concerns, should still have been involved at least as equally as the alternative caregivers in the discussions and decisions in regards to their baby’s care and health.

The exclusionary nature of the medical system towards women as mothers, and specifically within this hospital, operates in a less overt manner as well. The interview narratives reveal that some mothers appear to internalize the alienation and exclusion they experienced while at this hospital, to the point that they admitted to their CAS workers feeling uncomfortable, ashamed and/or anxious about asking questions of hospital staff. This is an additional way in which mothers are excluded from fully and comfortably experiencing, participating in and understanding their infant’s health and development while receiving perinatal care at this particular hospital.

### **Stigma in Action: The Paradoxical Nature of Service Involvement**

Related closely to the issue of exclusion discussed above is the theme that emerged around the contradictory manner in which stigma operates in the experiences of new mothers at the Brantford General Hospital. The paradoxical nature of stigma and service involvement -

increased monitoring and scrutiny alongside less consideration and acknowledgement - was described previously in the literature review section. While participants didn't use the term "paradox" specifically in the interviews, their narratives around certain situations and experiences made it evident that their clients had experienced this paradox related to stigma and service involvement within the Brantford General hospital.

As one participant described:

"...I guess my general perception is [the nurses] are cold towards the moms I've worked with and they're very structured, just go in do what they need to do and leave, no talking, no helping, no answering any questions really. But then they are quick to approach or call [CAS staff] to report everything they think this mom is doing wrong".

This participant recognized that a number of the issues faced by these women are larger, systemic issues that hospital staff would of course not be able to address independently, however, expressed feeling that there was still much room on the part of hospital staff to engage with these women in a more genuine, less hurried manner.

Another participant described the paradoxical manner in which stigma operates within the experiences of new mothers at this hospital when she spoke of a similar situation she had witnessed with one of her clients, who was both young and indigenous. This participant described how nursing staff had deemed this mother "aggressive" because she was upset with staff and yelled at them at one point during her delivery, when she had been given a medication she had declined initially; this young woman told her worker (this participant) that she had felt

that staff had been wrong in administering this medication in spite of her wishes, and that she had been angry and upset because of this.

This participant advised that she had never had any concerns around this young woman's behaviour herself and spoke of how nursing staff, because they had marked her as being aggressive, insisted that the door to this patient's room remain open at all times, including when family and/or CAS staff were present and trying to have a private conversation or visit with this woman. This participant talked of witnessing very impersonal, abrupt interactions on the part of nursing staff towards this woman and her new baby, and she contrasted these detached and hurried exchanges to the constant monitoring this new mother was, on the other hand, expected to tolerate because of how she had been (quickly and unfairly) labelled by staff.

These narratives mirror existing literature around the paradoxical manner in which stigma can take shape in people's lives. Once certain women were assessed negatively by hospital staff, they were treated negatively and judgementally for the duration of their stay at this hospital; and again, based on the narratives provided by participants, these judgements appear to be more automatic and severe when a mother is young and/or indigenous. These mothers' wishes and opinions were ultimately disregarded, but simultaneously, surveillance and scrutiny of them was increased and justified by hospital staff.

### **Birth Alerts: "A Necessary Evil"**

Another clear theme that emerged from the interviews was participants' concern around Brant FACS' birth alert document. A birth alert is a document that CAS staff complete and forward to local hospitals when it is felt that there are significant child protection concerns and hospitals need to be alerted to this, and their need to contact the Society, if/when this mother attends their hospital to give birth.

In general, the birth alert documents outline the client's information, what the child protection concerns are, the access plan following the delivery (i.e. can the baby room in with the mother, who can visit with the baby), any safety or security issues for staff, as well as information in regards to the discharge plan for the baby.

While all of the participants expressed feeling that birth alerts are needed in certain instances, there was a general sentiment that these documents are problematic because they almost automatically set mothers up to be viewed negatively by hospital staff

One participant described birth alerts as being "frustrating" and explained:

"...there's the child protection piece of me that says for sure we need these when there's a solid, safety and child protection reason, but then another piece of me knows how staff will judge these and will judge families when an alert is sent out".

This participant expressed feeling that the birth alert documents, by virtue of the language used and the information asked for, are "very judgemental and forensic".

When speaking about birth alerts, another participant referred to them as being "a necessary evil" and went on to state that:

"...if we've sent a birth alert, [hospital staff] have already decided how things are going to go down it seems, I don't think it's fair...they've already made judgements about the family and about what CAS should be doing just based on the alert".

The narratives expose significant concerns with Brant FACS' birth alert document and how this is interpreted and applied by hospital staff. This document is essentially a textual representation of surveillance between Brant FACS and the Brantford General Hospital. While all of the participants expressed feeling that birth alerts are necessary in certain instances, this document is problematic in the sense that it routinely sets mothers up to be regarded, automatically and often lastingly, by hospital staff as purely "a collection of risk factors to be managed" (Brown, 2006, p. 355). This document gives hospital staff permission to monitor and regulate certain women more harshly, and this has serious implications in terms of the care and interactions that mothers receiving perinatal treatment at this hospital experience. What is further concerning is that, as revealed in the narratives, the negative implications of this document are oftentimes already at play before a woman has even been admitted to this hospital to deliver her baby.

### **Intersectionality: Age and Race**

Another theme that arose from the interviews had to do with intersectional or overlapping stigmas. The majority of the participants expressed feeling that the issues outlined above were compounded when the mothers they were working with were young and/or indigenous. It is significant to note, however, that only the participants working on Brant FACS' First Nations First Response team identified indigenous identity as being stigmatizing for mothers within this hospital; there was no recognition of this significant intersection by participants who do not work with this population. This signifies a potential (and concerning) lack of awareness or consideration on the part of some staff at Brant FACS around how race functions as a complex intersection in the lives and experiences of certain women the agency serves.

All of the participants expressed concern over the fact that younger mothers seem to frequently be viewed automatically and inevitably by hospital staff as being in need of child protection involvement. As previously discussed, a number of participants reflected on calls received from hospital staff simply expressing concern over a new mother's young age, with no other identified issues. Participants spoke of having received calls from hospital staff reporting a mother's young age as a concern, in spite of the fact that in many instances, these mothers possessed a number of strengths and had a great deal of positive support.

Three participants spoke of feeling that a mother's younger age resulted in poorer treatment than usual on the part of hospital staff. One participant spoke of finding that the younger mothers she worked with were "talked down to more, spoken to more rudely and judgementally". She went on to describe how the exclusion of certain mothers that occurs within healthcare settings appears to be compounded when patients are younger:

"[hospital staff] don't teach the younger moms it seems, they seem quite hard on them, and just brush them off".

Another participant described a situation she had witnessed wherein she felt the mother's younger age had played a role in terms of hospital staff's critical treatment of her:

"...the younger the mom, the more judgement there is from staff it seems. I worked with one mom who was quite young, and she had lice, and was having trouble breastfeeding so she was looked down upon almost right away I think because she was so young and was experiencing these other issues too".

When asked about whether she was aware of any of her clients having had positive experiences at this hospital, one participant expressed feeling that when things have gone more favourably for the mothers she has worked with, this was due to them being older:

“...with the older moms I’ve worked with, things seem to go better, more smoothly. When things haven’t gone well, the mothers were younger, – 16, 17, even 19 or 20 – this happened especially if a birth alert had been sent out”.

The two participants who work solely with indigenous families were very clear in naming racism as a source of the issues they described witnessing between some of the mothers they have worked with and hospital staff. One participant spoke of a situation she had experienced in her work with a new mother, describing that this woman was working the Brant FACS on a supportive basis and that the Society did not have protection concerns at that time. However, the worker reflected:

“...no matter what this mom did, the hospital would call me with a concern”.

This worker attributed these constant reports of non-child protection concerns in regards to this mother to racist attitudes and stereotypes amongst hospital staff, as this client had been indigenous:

“I strongly believe that some of these non-concerns that are reported are coming from racism. I would be so bold as to say that, that some of this is from racism and colonialism that we’ve sort of bumped up against”.

Another participant gave a rather startling example of what she felt were blatant racist stereotypes and attitudes in action within this hospital when she advised that on one occasion, a nurse had informed her that she asks that any women who identify as indigenous complete a urine sample upon being admitted because of the likelihood that they use drugs. According to this participant, this nurse seemed to justify this practice by explaining that this was undertaken to help the hospital determine what substances were present in a woman’s system upon arrival, versus what substances were present because they had been administered for legitimate reasons (i.e. by a medical professional during the woman’s hospital stay). This participant discouragingly pointed out how this nurse had specifically asked that these urine screens only be requested of women who identified as being indigenous.

Emerging from these narratives are significant issues around the apparent racist and ageist practices and beliefs that exist within, and impact upon, the care and service provision for mothers within this hospital. Age and race, specifically being young and/or indigenous, appear to amplify the stigmatizing experiences for women receiving perinatal care at this particular hospital.

### **Protecting Partnerships**

There was a general consensus among the participants that while they felt their direct supervisors were very supportive of any concerns they raised regarding this hospital, that any type of complaint or effort to address these issues would potentially not be as well received by



the agency at large. When asked about any efforts they may have taken to address concerns regarding hospital staff's treatment of and behaviour towards mothers involved with Brant FACS, a number of the participants spoke not only of concern around potentially damaging individual relationships with certain hospital staff members, but of disrupting the larger partnership between Brant FACS and the Brantford General Hospital. While participants were clear that they feel the issues described above need to be addressed and remedied, they were very aware of the fact that community partnerships are stressed within Brant FACS and as such, the possibility of harming the working relationship between these organizations was something that participants wanted to avoid. As one participant stated:

“I don't know if staff would be supported over [organizational] partnerships. Because collaboration and working collaboratively is an agency focus, and so if you are pushing back against another community partner, I don't know if that's going to be positively received...people may not know how to approach these difficult conversations so they just don't do it. And then they're worried again – are they going to be supported or not if they do bring these issues up with nurses and other hospital staff”.

Interestingly, one participant spoke of the authority of the medical system and how at times even CAS staff feel intimidated by this:

“...hospital staff are hospital staff, they're on a different pedestal sometimes...I probably wouldn't bring up any issues directly because I would be too scared of

backlash. We have to work with these people, I will come across them again, so I wouldn't take this on myself. The agency could and should though".

Ideally, the partnership between Brant FACS and the Brantford General Hospital would operate as a coordinated care relationship, with regular and open communication between staff and mutual clients. As the interview narratives highlight, however, this is frequently not the case. Instead, all of the participants expressed feeling that communication between CAS and hospital staff needs to be improved.

What is arguably particularly concerning about how the partnership between both organizations currently functions is that, based on the narratives, CAS staff themselves oftentimes feel intimidated in terms of addressing concerns with hospital staff. This is due both to feeling potentially unsupported by managers and directors at Brant FACS, as well as because of feelings of unease around challenging the behaviours and opinions of medical staff. This speaks to the immense authority afforded those working in medical contexts; even other professionals experience feelings of trepidation in terms of confronting issues within the medical field. The unease on the part of CAS staff in addressing any harmful treatment by hospital staff towards mothers they have worked with is very concerning as this arguably serves to keep hidden, and ultimately perpetuate the stigmatizing practices and processes at play within this hospital.

Suggestions were made by participants that joint training occur specifically in regards to anti-oppressive practice, and the role and mandate of the child welfare system (i.e. what is and is not a risk to infants and children, in which situations CAS can intervene). However, all of the participants raised concerns around how this training could be carried out logistically between

the two organizations (i.e. how could we get all the relevant staff together to attend this training, how could the training be properly geared towards both hospital and CAS staff).

Two participants spoke of having taken part in infant discharge planning meetings at a different hospital and expressed finding these extremely helpful in terms of improving joint communication and planning between the family and all relevant collaterals. It was recommended by both of these participants that such meetings occur within the Brantford General Hospital.

The manager who participated in this study was able to confirm that there is a liaison committee in place between the hospital and Brant FACS. While she felt that the work of this committee was in a fairly early stage, she advised that partners from both agencies seem to recognize that there are issues in the work between Brant FACS and the hospital with mutual clients that need to be further explored and addressed; it was promising to hear that this is in the works.

## **Findings and Discussion**

This study aimed to explore the stigmatizing practices and processes at play between Brant Family and Children's Services and the Brantford General Hospital, specifically as they impact on mothers who are involved with Brant FACS and also receiving perinatal care at the Brantford General Hospital.

Through interviews with four child welfare workers, it was found that mothers involved in child protection are heavily stigmatized when accessing perinatal care at the Brantford General Hospital. This was reflected in the participants' narratives about mothers they have worked with experiencing increased exclusion and surveillance, and more hurried and judgemental care within this hospital setting; these stigmatizing experiences are amplified when mothers are young and/or indigenous.

While this was a small study, because all hospitals and child welfare agencies in Ontario are regulated by the Ontario government (with the exception of certain child welfare agencies operated and controlled by various native bands), and they therefore operate under similar policies and practices, it is realistic to assume that the experiences of mothers within the Brantford General Hospital parallel those of women receiving perinatal care in other hospitals throughout Ontario. As such, while small in scope, findings from this study are arguably still quite significant in terms of their potential impact and applicability province-wide.

### **The Impact and Imposition of Middle-Class Values**

As discussed previously, existing literature speaks the very problematic nature of dominant discourses around "good mothering" and "good womanhood"; describing these discourses as significantly and negatively influencing the ways in which women are assessed and treated by police, the courts, healthcare professionals, social workers and the general public

(Minaker, 2015). When a woman is seen as living or acting in any manner outside of the societal ideal around mothering, or outside of any traditional feminine ideal for that matter, she becomes diminished in the public's opinion and is habitually cast, informally and/or formally, as a permanent "other" (Minaker, 2015; Savarese, 2015). Subsequently, "devalued" women and mothers often become the subject of multiple means of state-sponsored and state-justified regulation, surveillance, and even discipline in some instances (Minaker 2015). The themes of this study parallel these existing findings in the literature.

As the themes of this study demonstrate, women who mother outside of the dominant societal ideals face stigmatization when seeking perinatal care at the Brantford General Hospital. These processes appear to be exacerbated when the child welfare system is also involved, when mothers are young and/or indigenous, and when birth alerts are sent out. It was found that new mothers attending the Brantford General Hospital endure increased monitoring and scrutiny (often in the form of more frequent reports being made to CAS), exclusion from participation in and discussions around their infant's care and health, and an overall disregard for their wishes and experiential knowledge.

Mandell (2008) considers how the child welfare and healthcare systems are structures wherein dynamics related to state authority, surveillance, privilege and power are so intertwined with care that what has resulted are organizational cultures that predominately emphasize risk assessment and allow for the "...unquestioned imposition of standards of privilege in judging the adequacy of mothering done by those without privilege" (p. 244). The findings of this study and the themes that were unearthed exemplify Mandell's (2008) concept in action.

Women involved with the child welfare system frequently live and mother from the margins and for this reason do not always embody the dominant ideals of how women should

live, parent and present their bodies to the world. The findings of this study clearly demonstrate that certain mothers (i.e. young mothers, mothers who are not white, mothers living in poverty), based on the observations of their CAS workers, face negative judgement, scrutiny and exclusion when receiving perinatal care at the Brantford General Hospital.

What is further concerning about this is that, as the findings also reveal, these judgements of certain women by hospital staff often appear to be enduring in terms of impacting their entire hospital stay.

This speaks to Freud's (1999) concept and concern around how stigmatized individuals are often labelled not only enduringly, but also based predominantly on white, western, middle class values, and how such labels carry with them serious and lasting implications for the way people are treated. As Freud (1999) states:

“Description becomes prescription, which is then transformed in a desirable standard of normal behaviour to be upheld and maintained by the educational system, the religious system, the legal system, the healthcare system and to whichever section of the population has to measure up or be found deficient” (p. 336).

Savarese (2015) also addresses this issue (as well as the paradoxical manner in which stigma can operate in people's experiences of service involvement) when she describes how women involved in the child welfare system are often labelled, she states:

“[marginalized women’s] bodies are presented as always consumed by risk...these women are captured in a ‘double bind’ – as ‘the other’, they are always excluded from normalcy, yet constantly judged by a code they may not subscribe to and will never measure up to” (p. 103).

I would argue that it is these particular mechanisms – the “unquestioned imposition” of patriarchal middle class values around motherhood, and the oppressive and enduring manner in which people who fall outside of dominant norms are labelled – that are significant sources of the stigmatizing practices that certain mothers experience while accessing perinatal care at the Brantford General Hospital.

Returning to Deacon’s (2006) conceptualization of stigma as negative attitudes or ideologies that “...result in blaming, shaming and status loss for the stigmatized person or group”, it is evident that stigmatizing practices are at play for mothers who are involved with the child protection system, and also receiving perinatal care at this particular hospital (p. 421).

Deacon’s (2006) definition of stigma is particularly relevant to the findings of this study as the author speaks to the fact that stigmatization does not have to result in overt discrimination to be harmful and marginalizing. While some of the hospital practices were quite blatantly othering and discriminatory in nature, one nursing staff’s practice of asking only indigenous women to complete urine tests upon admission, for example, a great deal of stigmatization can and does occur in more hidden and insidious ways. This is evidenced through the findings related to the subtle forms of exclusion, surveillance, labelling and hurried treatment that participants talked of witnessing certain mothers experience while accessing care at the Brantford General Hospital.

### **Birth Alerts as a Source of Stigma and Surveillance**

A major concern that participants raised was in regard to the use of the birth alert document as a source of stigma and surveillance. As it currently exists, the birth alert document used by Brant FACS is quite structured and forensic in nature. It is also centred primarily around risk factors, and how these will be managed if necessary. There is no clear opportunity for CAS staff to outline the strengths and positive factors in regard to expectant mothers they are working with. The predominate focus on risk and safety measures in the current document sets clients up to be viewed, almost automatically and inevitably, as being “risky” or “bad”. A number of authors discuss the negative effects of standardized and primarily risk-focused assessments and descriptions of service users. These approaches are understood to dehumanize service users, effectively casting them as “...a collection of risk factors to be managed” (Browne, 2006, p. 368; Gillies, 2005; Pollack, 2010). Similarly, Elder-Woodward (2014) describes such assessments as only serving to “diminish the dignity of the service recipient” (p. 310).

The birth alert document appears to be the point at which the interplay of stigma and surveillance between Brant FACS and the Brantford General Hospital converge the most severely for expectant or new mothers involved with both organizations. That is, for mothers involved with both systems, it appears that the likelihood that they will face increased judgement, scrutiny and exclusion in the hospital setting is increased, almost to the point of inevitability, when a birth alert is sent out to the hospital.

### **Intersectional Analysis**

The findings from this study clearly indicate that for young and/or indigenous mothers, the stigmatizing processes operating within and between Brant FACS and the Brantford General



Hospital, - increased labelling, surveillance, and exclusion and more hurried care, for example - are exacerbated. The fact that ageism and racism arose as significant factors in participants' narratives and interpretations of stigma within this hospital supports the conceptualization of stigmatization as a relational process that mirrors and reproduces power and domination along existing hierarchies related to race, gender and age. (Link & Phelan, 2001; Parker and Aggleton, 2003).

In terms of the intersection of young age in particular, the narratives from this study echo existing literature in regards to medical professionals' common judgement of young mothers as problematic and immoral, and as bodies that "...went out of control and that demonstrated sexually deviant behaviour" and thus, bodies that require increased surveillance (Breheny & Stephens, 2007; Greene, 2008, p. 125; McDermott & Graham, 2005). Young mothers who receive perinatal care at this hospital are frequently regarded by hospital staff as being a detriment to their infants' care and wellbeing purely because of their age. This is evidenced by the fact that participants spoke of receiving more frequent calls about the young mothers they have worked with, as well as through participants' accounts of observing more hurried and judgemental treatment towards younger mothers by hospital staff.

Because these mothers, by virtue of their younger age, fall outside of the boundaries of "normal" (patriarchal) motherhood, they are forced outside of the boundaries of "normal" and appropriate care within this hospital. As a result, they experience increased surveillance and exclusionary practices, in comparison to mothers who are older and thus, regarded as more closely adhering to the dominant ideals around "good" motherhood.

The narratives from this study also raise important and concerning findings about the intersection of indigeneity and amplified stigmatization within the Brantford General Hospital.

In Canada, there exists a longstanding history of racism, marginalization and colonization against First Nations individuals (Blackstock, 2011; Blackstock, Trocme, & Bennett, 2004; Greene, O'Brien-Teengs, Whitebird & Ion, 2014; Mill, Edwards, Jackson, MacLean, & Chaw-Kant, 2010). The legacy of certain racist and colonizing practices persist across Canada today – residential schools and the trauma perpetuated within these institutions are one example of awful racist and assimilationist practices whose impact endures (Blackstock, 2011; Blackstock et al., 2004; Greene et al., 2014; Mill et al., 2010).

Colonial images and stereotypes of indigenous women and mothers as being immoral, irresponsible, and neglectful endure today and have resulted in the “inferiorization of indigenous mothering” (Browne, 2005, p. 67; Gosselin, 2006; Mzinegiizhigo-Kwe Bedard, 2006). These stereotypes continue to inform the Canadian consciousness, and very much influence how indigenous women are treated by both the general public, as well as within state institutions (Mzinegiizhigo-Kwe Bedard, 2006). Browne (2005) states that healthcare in Canada continues to “unfold against a backdrop of colonial relations” and that harmful colonizing beliefs on the part of medical professionals continue to intensify othering experiences for indigenous individuals within healthcare contexts, pushing this population further to the fringes of healthcare, and resulting in consistently poorer health outcomes for indigenous individuals (Browne, 2007; Mill et al., 2010). Findings from this study would suggest that such colonial stereotypes are at play within the Brantford General Hospital and that these influence the type of treatment that indigenous women accessing perinatal care at the hospital experience.

The study participants who work exclusively with indigenous families were very clear in naming racist and colonial attitudes as a source of the stigmatizing and judgemental treatment that a number of mothers they have worked with have endured while receiving care at this

hospital. Clear and fairly startling accounts were provided by these participants of indigenous mothers not only being scrutinized, negatively labelled, monitored and reported to CAS more frequently, but being expected to submit to intrusive and blatantly discriminatory practices by hospital staff by virtue of their race.

The narratives provided by participants echo existing findings that being indigenous is in and of itself a stigmatizing condition that results in indigenous individuals experiencing “a layering of stigma” within the medical system (Mill et al., 2010, p. 1470).

It is significant to note, however, that only the participants working on Brant FACS’ First Nations First Response team acknowledged indigenous identify as being stigmatizing for mothers within this hospital; there was no recognition of this significant intersection by participants who do not work with this population. This signifies a potential (and concerning) lack of awareness or consideration on the part of some staff at Brant FACS around how race functions as a complex intersection in the lives and experiences of many women we work with.

Many child welfare agencies in Ontario have implemented an anti-oppressive approach into their work with clients (Wong & Yee, 2010). Anti-oppressive practice is defined as “...the lens through which one understands how race, gender, sexual orientation, identity, ability, age, class, occupation and social service usage can result in systemic inequalities for particular groups” (Wong & Lee, 2010, p. 6). There is an expectation that critically reflexive practice occur as part of AOP (Wong & Lee, 2010). This definition of anti-oppressive practice is important to note as Brant FACS espouses strong values around incorporating an AOP approach in its work with service users. However, the fact that the participants not working with indigenous families did not identify race as a potential source of stigma, speaks to the fact that AOP, in terms of its

emphasis on fully and critically considering how various intersections result in oppression for people, is arguably not being implemented as fully as it should be within the agency.

Further, and related to this lack of awareness on the part of some participants around race as an overlapping stigma, is the fact that apart from recognizing the issues with Brant FACS' current birth alert document, participants did not identify any other ways in which Brant FACS is potentially implicated in the perpetuation of the stigma that many mothers we work with experience while receiving care at the Brantford General Hospital. This is significant as it implies that the critical social work and reflexivity elements of AOP are not present to the extent that they should be, particularly within an agency that has such a strong stance in terms of the necessity and benefits of practicing from an AOP framework. While Brant FACS' birth alert document requires attention and modification, there are numerous other ways – the language we use, a lack of proper advocacy with clients, workers' own biases and judgements, an emphasis on protecting collateral partnerships instead of properly and fully tackling injustice and oppression in the lives of clients, for example – that Brant FACS' practices and policies maintain, and potentially even intensify, the stigma that many mothers we work with endure while receiving perinatal care at our local hospital.

If Brant FACS wants to truly operate from an anti-oppressive standpoint, then this critical reflexivity piece must be incorporated into practice genuinely and continually. CAS staff must not forget or overlook their privileged positions and this includes reflecting on how our actions, or lack thereof, have the potential to maintain and exacerbate issues of stigma, injustice and oppression in the lives of service users. If these elements of AOP are not being implemented, then an AOP framework is only being applied in a rather superficial sense. Possible

recommendations about how this can be achieved more fully within the agency are outlined in following section.

## **Recommendations**

### **Brant FACS' Birth Alert Document**

While birth alerts are necessary in certain instances, the existing document - the information it asks for, how it is received and likely judged by hospital staff - seems to result in the convergence of the stigmatizing surveillance and assessment practices inherent to both the child welfare and healthcare systems. This document appears to almost generate, amplify and justify the “multiple modes of surveillance” that marginalized women often face in their interactions with different health and social service agencies (Greene et al., 2015, p. 232).

On this basis, Brant FACS' birth alert document would be a good starting point in terms of beginning to address some of the stigma – and ensuing exclusionary, judgemental and scrutinizing treatment - that mothers involved with both Brant FACS and the Brantford General Hospital appear to experience fairly routinely. Although individual values and beliefs will likely always influence how birth alerts are completed by Brant FACS staff, and how they are subsequently received and interpreted by hospital staff, there are nonetheless changes that could be made that could lessen its potentially stigmatizing impact for our mutual clients.

One study participant recommended that training be offered to staff specifically around completing birth alerts – when and why they are needed (i.e. not simply as a “heads up” to the hospital, but rather, when there are solid, serious child protection concerns). When feasible and appropriate, the birth alert documentation could be completed openly with clients, so as to allow for better transparency and collaboration, and where possible, the inclusion of the clients' own voice and plan. The document could be made less forensic in nature. This could be accomplished, arguably and importantly, via the inclusion of a section that solicits information in regards to strengths, protective factors and/or positive features that a client possesses or

demonstrates, or that exist within the family. Including such a section would not only better align with Brant FACS' espoused values of an anti-oppressive and strengths-based approach to working with families, but could potentially work against the routinely negative judgement of service users that the current document produces. Allowing for space to speak to strengths, and when possible including clients in the completion of the birth alert documentation, could perhaps also work to combat the paradox of increased monitoring alongside less consideration and acknowledgement of service users' needs and experiential knowledge that occurs so often for stigmatized individuals in the context of social and human service involvement.

### **Brant FACS' AOP Committee**

Brant FACS has an AOP committee that meets regularly to discuss AOP implementation within the agency. As part of this committee, regular informal discussion groups are held that all staff are invited to attend. These focus on different topics around oppression and social justice, both within the agency and the community at large. A further recommendation for Brant FACS would be that the problem of stigma within the Brantford General Hospital, and the ways in which Brant FACS' practices and policies contribute to this, be the focus of future AOP discussion groups. This would bring further light to this problem, as well as better ensure that Brant FACS staff are critically reflecting on this issue in terms of how our own work contributes to this, how we can better support the mothers we work with, and potential ways in which this issue can be alleviated within and between both organizations.

### **Working Together: Further Points of Intervention**

Arguably hospital staff and child protection workers do not intentionally adopt the wider harmful social discourses that result in stigmatization and oppression for the individuals we serve. Certainly, human and social service organizations are "filled with individuals who are

deeply committed to their professional work, who are regarded as highly skilled practitioners, [and] who believe themselves to be liberal [individuals] (Browne, 2005, p. 81). However, there is clearly a concerning gap in terms of a lack of awareness or consideration of how certain harmful discourses and stereotypes continue to permeate and influence practice within and between Brant FACS and the Brantford General Hospital.

The multiple sites of stigmatization for mothers between Brant FACS and the Brantford General Hospital illuminate the need for interventions that confront and alter certain institutional policies, and individual practices and beliefs, at play within both organizations.

Important recommendations were made by all participants that joint training occur, specifically in regards to anti-oppressive practice, colonization, and the role and mandate of the child welfare system (i.e. what is and is not a risk to infants and children, in which situations CAS can intervene). However, concerns exist around how this training could be carried out logistically between the two organizations (i.e. how could we get all the relevant staff together to attend this training, how could the training be properly geared towards both hospital and CAS staff).

Greene et al. (2017) state that in order for meaningful change to occur, advocates must be positioned in such a way as to ensure the proper uptake of any recommended strategies. Thus, a further recommendation would be that Brant FACS and the Brantford General Hospital look at the feasibility of having a child protection worker housed within the hospital. While there are hospital social workers, the role of a Brant FACS worker in the hospital would be different and could allow for increased and closer consultation and education between both organizations in terms of what does and does not constitute risk, how to provide more coordinated care and



service, and most importantly, how to more justly and compassionately serve the mothers we mutually encounter.

At minimum, Brant FACS and Brantford General Hospital staff need to understand and acknowledge just how entrenched and extensive stigmatization continues to be for many of the mothers we work with. Both organizations need to begin to jointly acknowledge the continued and very real impact that colonization, sexism, racism, and classism have on the care and treatment experiences of mothers involved with both systems. There is also a need for both organizations to confront the patriarchal nature of the discourses that we jointly employ to judge and assess mothers; there needs to be a recognition that there exist different ways of mothering related to personal experience, culture and so on, and that these alternative means of childrearing are not inevitably illegitimate or unsafe, simply because they do not adhere to dominant norms around mothering.

These important conversations could be happening within the liaison committee that is in place between Brant FACS and the Brantford General Hospital. It is essential, however, that these conversations include the voices of frontline staff at the agency, and that any recommendations or decisions made at the committee-level are properly disseminated to all staff in both settings. Ideally, discussions occurring amongst members of this committee could also include the voices and opinions of mothers involved with both systems. How this could be appropriately and genuinely accomplished requires further discussion.

### **Limitations**

While this project provided important insight into the topic of study, there are nevertheless several constraints that limit the applicability of these findings. The first of these relates to the scale and scope of this project, which was restricted due to the rather limited timeframe of an MSW thesis project. This resulted in fewer interviews being conducted and included in this project.

Further, time constraints created some challenges in conducting this research in a manner that fully aligns with the principles of the theoretical frameworks guiding this project. Specifically, critical social work theory puts forth, and is critical of the fact, that the voices of the most privileged are typically afforded the most weight and value (Fook, 2003). Clearly, this study solicited the narratives and opinions of a generally privileged and authoritative group of people - child protection workers. While staff bring to their work their diverse life experiences and varied encounters with different types of privilege and oppression, by and large, child welfare workers, by virtue of their title, are afforded a significant amount of authority while at work. As such, the findings of this study are limited in terms of reflecting only the voices of a fairly exclusive group of people.

### **Future Directions**

Admittedly, the initial hope for this study was to interview women who had given birth at this hospital while concurrently involved with Brant FACS. However, due to concerns that arose around sampling within the smaller timeframe of an MSW thesis project, it was eventually decided that CAS staff would be interviewed as a starting point, so as to determine whether or not other child protection staff had concerns in regards to this hospital's treatment of clients, as well as Brant FACS' work with this hospital.

While I would argue that this study is a good starting point in terms of beginning to explore the problem being looked at, and providing some meaningful findings and recommendations, the hope is that this project can be continued. My potential plan is to return to school and carry on with the study of this topic by interviewing not just nursing staff, but more importantly, the women who have given birth at this hospital while simultaneously being involved with the child welfare system. My hope is that I could do this by employing a community-based approach to research so that the voices of these women would be included in the literature in as genuine and non-tokenistic manner as possible.

By gathering and including narratives directly from women who have given birth at this hospital I would hope to, if not flip the dominant discourse – as this will likely take a great deal of time and resistance – at least present an often overlooked, alternative way of knowing and understanding; namely, the true and genuine accounts of women who gave birth at this particular hospital, who were also clients of CAS at the time.

Fook (2012) states that:

“the assumptions of the universality of the perspectives and experiences of the privileged are dislodged when the oppressed themselves expose those assumptions by expressing positive images of their experience. By creating their own cultural images they shake up the received stereotypes about them” (p. 128).

My goal of any future research I may conduct would be that it affords genuine space for alternative viewpoints and images to be shared, heard and presented so as to begin to “shake up” the harmful practices and dynamics that seem to occur within and between the child welfare and healthcare systems.

## Conclusion

While this research project serves only as a starting point in terms of exploring and addressing the issues of stigma for mothers between Brant FACS and the Brantford General Hospital, it is hoped that this study shed some light on the stigmatizing attitudes and practices that new mothers often endure when they are involved with Brant FACS and the Brantford General Hospital concurrently.

Link and Phelan (2001) argue that it is vital that interventions directed towards stigma be multifaceted and multilevel in order to address the numerous mechanisms that contribute to stigma at both the individual and structural levels. They state, however, that more importantly, efforts to change stigma need to bring attention to, and fundamentally alter “the deeply held attitudes and beliefs of powerful groups that lead to labelling, stereotyping, setting apart, devaluing and discriminating” (Link & Phelan, 2001, p. 381). It is hoped that this project begins to disrupt, even minimally, the processes and forces inherent to two very powerful structures – the child welfare and healthcare systems - that prevail and that allow the themes unearthed in this research project to occur to the extent that they seem to for certain women.

It is important to note here that the problem of stigma, and the other troubling themes that emerged throughout this project, are of course not issues whose cause and perpetuation lie solely with individual child welfare and hospital staff. They reflect structural and societal problems at large and are influenced by myriad factors, not limited to individual values and biases, organizational policies, and political (neoliberal) views and agendas.

It was my hope and intention that this research brings about meaningful change in terms of challenging and altering the harmful values and policies that cause and perpetuate the experiences of stigma that mothers involved with Brant FACS endure while accessing perinatal

care at the Brantford General Hospital. More collaboration and consideration on the part of Brant FACS staff when completing birth alerts, the comprehensive modification of Brant FACS' birth alert document altogether potentially, and improved coordinated care between Brant FACS and the Brantford General Hospital are just a few intended points of intervention that arose from this study. The fundamental goal of this project (and any future related research that may be conducted) is that it serves to improve the care and birth experiences of women impacted by the complex, overwhelming and oftentimes very stigmatizing mechanisms that function within and between Brant FACS and the Brantford General Hospital, and that are amplified when these systems operate in certain women's lives simultaneously.

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## **Appendix A**

### **Email Recruitment Script Sent on Behalf of the Researcher by the Holder of the Participants' Contact Information**

**Meredith Berrouard, BA, BSW**  
Masters Candidate in Social Work, McMaster University

#### **Study Title:**

Medicine, Monitoring and Motherhood: An Exploration of the Interplay Between Stigma and Paradox in the Child Welfare and Healthcare Systems

---

Dear Brant Family and Children's Services staff,

Meredith Berrouard, a McMaster student and Brant FACS employee, has requested that we let staff know of a study that she is conducting about the stigma that Brant FACS clients may experience in the healthcare system as a result of their concurrent child welfare involvement with our agency. This research is part of her Masters of Social Work program at McMaster University.

If you are interested in getting more information about taking part in Meredith's study please read the brief description below and contact Meredith directly using her McMaster email address: berroum@mcmaster.ca. The researcher will not tell me or anyone else at Brant Family and Children's Services who participated or not.

Meredith Berrouard is inviting staff who have experience in Family Service and/or Intake work at the agency to take part in a 45-60 minute face-to-face interview. Meredith will be conducting these interviews and they will take place at one of the Brant FACS offices, or another place of convenience to participants, during a time that is also convenient to participants. The agency will support staff in completing these interviews during work hours, if this works best for people's schedules. Meredith will work out the details with you in terms of time, location and so on. She hopes to learn what attitudes child protection workers perceive nurses to have towards women who have recently given birth and who are involved with the child welfare system, and how child protection workers have responded to nurses who have expressed negative attitudes towards these women.

Meredith has asked us to attach a copy of her Letter of Information to this email. This letter provides full details about the study.

In addition, this study has been reviewed and cleared by the McMaster Research Ethics Board. If you have questions or concerns about your rights as a participant or about the way the study is being conducted you may contact:

McMaster Research Ethics Board Secretariat  
Telephone: (905) 525-9140 ext. 23142  
Gilmour Hall – Room 305 (ROADS)  
E-mail: [ethicsoffice@mcmaster.ca](mailto:ethicsoffice@mcmaster.ca)

Sincerely,  
Gisele Tarraba  
Quality Assurance Manager, Brant Family and Children's Services

## Appendix B



### LETTER OF INFORMATION/CONSENT FORM

*Medicine, Monitoring and Motherhood: An Exploration of the Interplay between Stigma and Paradox in the Child Welfare and Healthcare Systems*

**Principal Investigator:**

Dr. Jim Gladstone  
School of Social Work  
McMaster University  
Hamilton, Ontario, Canada  
(905) 525-9140 ext. 23786  
E-mail: jwgladstone@rogers.com

**Student Investigator:**

Meredith Berrouard  
School of Social Work  
McMaster University  
Hamilton, Ontario, Canada  
E-mail: berroum@mcmaster.ca

**What is the purpose of this study?**

You are invited to take part in a study about the stigma that child welfare clients, particularly mothers, may have experienced within the healthcare system as a result of their involvement with child protection services. I am interested in learning about what attitudes child protection workers perceive hospital staff to have towards women who have recently given birth and who are involved with the child welfare system. I am also hoping to learn more about how child protection workers may have responded to hospital staff who have expressed negative impressions towards these women. I am doing this research as part of my thesis for my master of social work degree, with the supervision of Dr. Gladstone at McMaster University.

**What will happen during the study?**

The study involves a one-on-one interview with myself (Meredith Berrouard) that should take approximately 60-90 minutes to complete. The interview will take place at one of the Brant FACS offices, or another location in the community that is convenient for you and that allows for adequate privacy. To keep track of what has been said, I will be taking some hand-written notes, as well as audio-recording the interview, with your permission.

Examples of some questions you may be asked are:

- Can you tell me about your role at Brant FACS
- Can you describe in what context you've interacted with staff at our local hospital
- Can you describe how you feel these interactions went for yourself? For your client(s)?

To begin with, I will introduce myself and provide a brief explanation of my research, including going through this Letter of Information/Consent Form. Next, you will have the opportunity to review the complete list of questions prior to beginning the interview, and make note of any questions you do not feel comfortable answering. I will also confirm that you are comfortable with me taking written notes and audio-recording the interview. I may ask you specific follow-up questions based on what you share, which you can choose to answer or not. We can also take a break whenever needed.

**Are there any risks to doing this study?**

The risks involved in participating in this study are minimal. Some of the topics discussed may make you feel uncomfortable. The interview itself will last approximately 60-90 minutes, which may be draining. Breaks can be

taken as needed to alleviate this. You do not need to answer any questions that you do not want to answer or that make you feel uncomfortable. You are welcome to stop the interview at any time with no consequences. While no one except myself will know whether you were in the study unless you choose to tell them, we are sometimes identifiable through the stories we tell, and the Brant FACS and Brantford communities are not very large. Although considered minimal, this is a potential social risk. I describe below the steps that I am taking to protect your privacy.

#### **Are there any benefits to doing this study?**

The research will likely not benefit you directly. I hope to learn more about what attitudes healthcare staff hold towards mothers whom they know are also involved in the child welfare system. Additionally, I am hoping to learn more about the ways that child protection workers may have addressed any negative attitudes held by hospital staff towards child protection clients. I hope that the results of this study can be used to begin to address any stigma that child protection clients might experience in other areas of their lives, specifically in the healthcare system, because of their involvement with child welfare services. My hope is that the overall care and treatment experiences of women involved with both the child welfare and healthcare systems can be as positive and non-judgemental as possible.

#### **Reimbursement**

You will receive a \$5 Tim Horton's gift card as a token of appreciation for your time and contribution to this project.

#### **Who will know what I said or did in this study?**

You are participating in this study confidentially and every effort will be made to protect your privacy. I will not use your name or any information that would allow you to be identified. No one except myself will know whether you were in the study unless you choose to tell them. However, we are sometimes identifiable through the stories we tell, and the Brant FACS and Brantford communities are not very large - please keep this in mind in deciding what to tell me. Pseudonyms may be used as necessary, and any key points that include identifying information can be edited to protect privacy.

The information you provide on this form, as well as my handwritten interview notes, will be kept in a locked cabinet only I will have access to. Interview recordings and other electronic data will be kept on a computer, protected by password. Once the study is complete and a final draft of my thesis has been submitted, all data will be destroyed (i.e. by September 2017).

#### **Legally Required Disclosure:**

Although I will protect your privacy as outlined above, if the law or duty requires it, I will have to reveal certain personal information in the following circumstances:

- If I am concerned that you are at immediate risk of harming yourself or someone else, I will be required to tell someone and take steps to minimize this risk
- If you tell me that there is a child under the age of 16 who is experiencing abuse and/or neglect, I have a duty to report this to the local Children's Aid Society
- If you tell me that you were sexually abused by a helping professional (e.g. doctor, psychologist), and you tell me their name, I have a duty to report this information to their professional college
- If for some reason, my records are subpoenaed by a court of law, I will be required to comply and provide this information

If one or more of these situations does arise, however, I will do my best to let you know before any action is taken.

#### **Where will my data be kept?**

After your interview, the recorded audio file will be transcribed into a Word document, and the audio file will be destroyed. Your interview transcript and signed consent will be kept in a locked cabinet. All data will be destroyed once a final draft of my thesis has been submitted and approved (i.e. by September 2017).

#### **What if I change my mind about being in the study?**

Your participation in this study is completely voluntary. It is your choice to be part of the study or not. If you decide to be part of the study, you can withdraw from the interview for whatever reason, even after signing the consent

form, or partway through the interview. You will have up until June 23, 2017 to withdraw your participation, at which point I expect to begin completing and submitting my graduate thesis.

If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study. Your decision whether or not to be part of the study will in no way affect your relationship with McMaster University's School of Social Work.

**How do I find out what was learned in this study?**

I expect to have this study completed by August 2017. If you would like a brief summary of the results, please let me know how you would like it sent to you below. It should be sent out in Summer 2017.

**What will the findings from this research study be used for?**

The information collected during this research project will be used to write my masters thesis.

**Questions about the Study:**

If you have questions or need more information about the study itself, please contact me at:

Meredith Berrouard  
*berroum@mcmaster.ca*

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat  
Telephone: (905) 525-9140 ext. 23142  
C/O Research Office for Administrative Development and Support  
E-mail: [ethicsoffice@mcmaster.ca](mailto:ethicsoffice@mcmaster.ca)

**CONSENT**

- I have read the information presented in the information letter about a study being conducted by Meredith Berrouard of McMaster University.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I understand that if I agree to participate in this study, I may withdraw from the study at any time or up until approximately June 23, 2017
- I have been given a copy of this form.
- I agree to participate in the study.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Participant (Printed): \_\_\_\_\_

1. I agree that written notes can be taken during this interview.

Yes

No

2. I agree that the interview can be audio recorded.

Yes

No

3.  Yes, I would like to receive a summary of the study's results.

Please send them to me at this email address: \_\_\_\_\_

Or to this mailing address: \_\_\_\_\_

\_\_\_\_\_

No, I do not want to receive a summary of the study's results.

4. I agree that the researcher may contact me again at a later today to clarify or confirm information if necessary.

Yes

No

## Appendix C

### Interview Guide

This guide gives you an idea as to what I am hoping to learn in terms of what attitudes child protection workers perceive hospital staff to have towards women who have recently given birth and who are also involved with the child welfare system, and how child protection workers may have responded to hospital staff who have expressed any negative impressions towards these women. Sometimes I will ask additional questions not included below in order to make sure that I understand what you have told me, to get more information in regards to something you have said and/or to learn more about what you think or feel about something. As with all other questions, it is your choice whether or not you answer these. Please note that while your identity will be kept anonymous, we are sometimes identifiable through the stories we tell; please be mindful of this when deciding what to share with me.

---

**1) Can you tell me a little bit about your current role at Brant FACS.**

- How long have you been working at the agency for?
- How long have you been in your current position for?

*Okay, now I would like to begin discussing any experiences you may have had working with hospital staff as part of your role at Brant FACS...*

**2) Can you describe in what context(s) you have interacted with hospital staff, particularly, on the maternity ward, as part of your role at Brant FACS.**

- What hospital staff did you interact with? Nursing staff? Doctors?
- What was the purpose of these interactions?
- How do you feel these interactions went?
- Were any outcomes you hoped for achieved as a result of these interactions with hospital staff?
- How would you describe the agency's relationship with our local hospital in general? And particularly with staff on the maternity ward?

**3) Can you describe times that you've witnessed interactions between hospital staff on the maternity ward and any of your clients, specifically mothers or expectant mothers.**

- How do you feel these interactions went for your client(s)?
- Do you think these interactions were experienced as positive or negative by clients? Why?
- How have you felt about the interactions you've witnessed between hospital staff and your clients?
- What specific differences, if any, have you noticed between your own interactions with hospital staff and your clients' interactions with hospital staff?
- What did you think were the reasons for these differences?

**4) Have you ever talked with any of the mothers you've worked with about their personal feelings or experiences around the care and treatment they received when giving birth at the hospital?**



- Did clients bring this up with you spontaneously, or did you ask them about their experiences in this regard?
  - If you have discussed this with clients, what did they have to say about this; how did they describe these experiences?
  - What do you think would stop child protection workers from discussing this with their clients?
- 5) **Have you been aware of any of your clients having positive experiences in terms of their care and treatment on the maternity ward at the hospital?**
- Did your client(s) say what made these experiences positive for them?
  - If not, what do you think made these experiences positive for clients?
- 6) **Have you ever tried to engage hospital staff in conversations around any judgmental or negative treatment you may have witnessed or been aware of by hospital staff towards any of the women you've worked with?**
- If so, what specific staff members did you speak to about this?
  - How did these conversations go? Did you feel hospital staff were receptive to engaging in these conversations with you?
  - If not, do you have any thoughts around why staff weren't receptive?
  - If you felt staff were receptive to these conversations, why do you think this was the case? What did you feel was positive about these conversations?
  - Have you engaged in any other efforts to address any concerns you may have had around the hospital's work or treatment of CAS clients?
  - What do you think would stop child protection workers from engaging in these conversations with hospital staff?
- 7) **What changes, if any, would you like to see in terms of how Brant FACS works with our local hospital?**
- Do you have any suggestions in terms of how these changes could be brought about?
  - Do you have any ideas around how CAS staff could better engage with hospital staff around this issue?
  - Do you have any ideas around how Brant FACS as an agency could do more work in terms of addressing this issue and better engaging hospital staff in these conversations?
- 8) **What changes, if any, would you like to see in terms of how the hospital engages with CAS clients?**
- Do you have any suggestions in terms of how these changes could be brought about?
- 9) **Is there anything else that you would like to share? Is there anything else that I have forgotten that you think is important to include?**

*Thank you very much for your time and valued input, ideas and experiences. It is sincerely appreciated.*