

Promoting Access to Breastfeeding in Child Welfare Matters

A Joint Special Report

August 2018



Ministry of
Children and Family
Development

August 29, 2018

The Honourable Darryl Plecas
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Mr. Speaker,

We have the honour of submitting to the Legislative Assembly of British Columbia this joint special report *Promoting Access to Breastfeeding in Child Welfare Matters*. This report is prepared in accordance with Section 20 of the *Representative for Children and Youth Act* and s. 93(2) of the *Child, Family and Community Service Act*.

Sincerely,



Katrine Conroy
Minister of Children
and Family Development



Bernard Richard
Representative for
Children and Youth

pc: Mr. Craig James, QC
Clerk of the Legislative Assembly

Mr. Nicholas Simons, MLA
Chair, Select Standing Committee on Children and Youth

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Introduction

This Joint Special Report is a collaborative initiative undertaken by the Ministry of Children and Family Development (MCFD) and the Representative for Children and Youth (RCY).

Earlier this year, RCY and the public became aware of an Indigenous infant who had been removed from a mother's care by MCFD three days after birth. The lawyer for the mother's community petitioned the B.C. Supreme Court on behalf of the mother, requesting that she have daily access to her newborn. After an unprecedented hearing, the court ordered MCFD to increase the mother's access to her infant for breastfeeding and bonding. Shortly after, the Provincial Court ordered the infant be returned to the mother, finding that the ministry had not adequately considered less disruptive measures for the family and, specifically, the supports that were available in the community to keep the mother and infant together.

While this was a highly public case and decision, MCFD makes decisions every day that balance the safety of newborns with the importance of maintaining parental access to promote attachment between infants and their parents and breastfeeding or access to breastmilk. Many variables influence MCFD's planning in this regard, including the risks and strengths within the family involved, the support of family and community and the availability of support and services, including visit supervisors.

For this report, RCY and MCFD have collaborated to examine what policies and practices could be enhanced or introduced in this province to strengthen families' capacity to care for infants, support access to breastfeeding or breastmilk and potentially prevent the unnecessary removal of infants. This collaboration between RCY and MCFD is in keeping with the vision of the Honourable Ted Hughes in his 2006 *B.C. Children and Youth Review*, when he recommended that the Representative "... take part in the development of policies or practices that reflect a deeper understanding of the needs and interests of children, youth and their families."¹

¹ Honourable Ted Hughes OC, QC, LL.D. (2006). *BC Children and Youth Review: An Independent Review of BC's Child Protection System*.

Methodology

This report has been informed by a review of relevant literature as well as comparative information drawn from child welfare jurisdictions across Canada. It was also informed by visits to model support programs at Fir Square and Sheway in Vancouver. Also incorporated in the report is recent MCFD data on infants who entered care within 12 months of birth, an analysis of RCY advocacy data in instances where access or custody to support breastfeeding was a concern, RCY case studies and examples of best practices.

Background

Child protection services are intended to safeguard children from harm. The *Child, Family and Community Service Act (CFCS Act)* is the legislative authority for the ministry's Child Protection Services (CPS). In cases where there is reason to believe that a child needs protection, workers are required to conduct investigations, assess risk to the child and determine the most appropriate action. The *CFCS Act* requires that the actions taken are consistent with the best interests of the child, and that least disruptive measures are considered when a child needs protective services.

In circumstances where it is unsafe for a child to remain in the care of his or her parent(s), placement outside the home may be required. Infants can be placed in out-of-care home arrangements through either a placement with extended family, a voluntary agreement with the parents, or by removal. Voluntary Care Agreements (VCAs) are made between the ministry and the parent, allowing MCFD to care for the child when the parent is temporarily unable to do so. Infants are removed when their health or safety is either in immediate danger or no other less disruptive measure is available or adequate to protect the infant.

Definitions

Director: a person designated by the minister under s. 91 of the *CFCS Act*. Directors delegate social workers to provide services under the *Act*.

Remove: to take a child into the care of a Director under s. 30, 36 or 42 of the *Act*.

Voluntary Care Agreement: A Director may make a written agreement with a parent who has custody of a child and is temporarily unable to look after the child in the home under s. 6(1-8) of the *Act*.

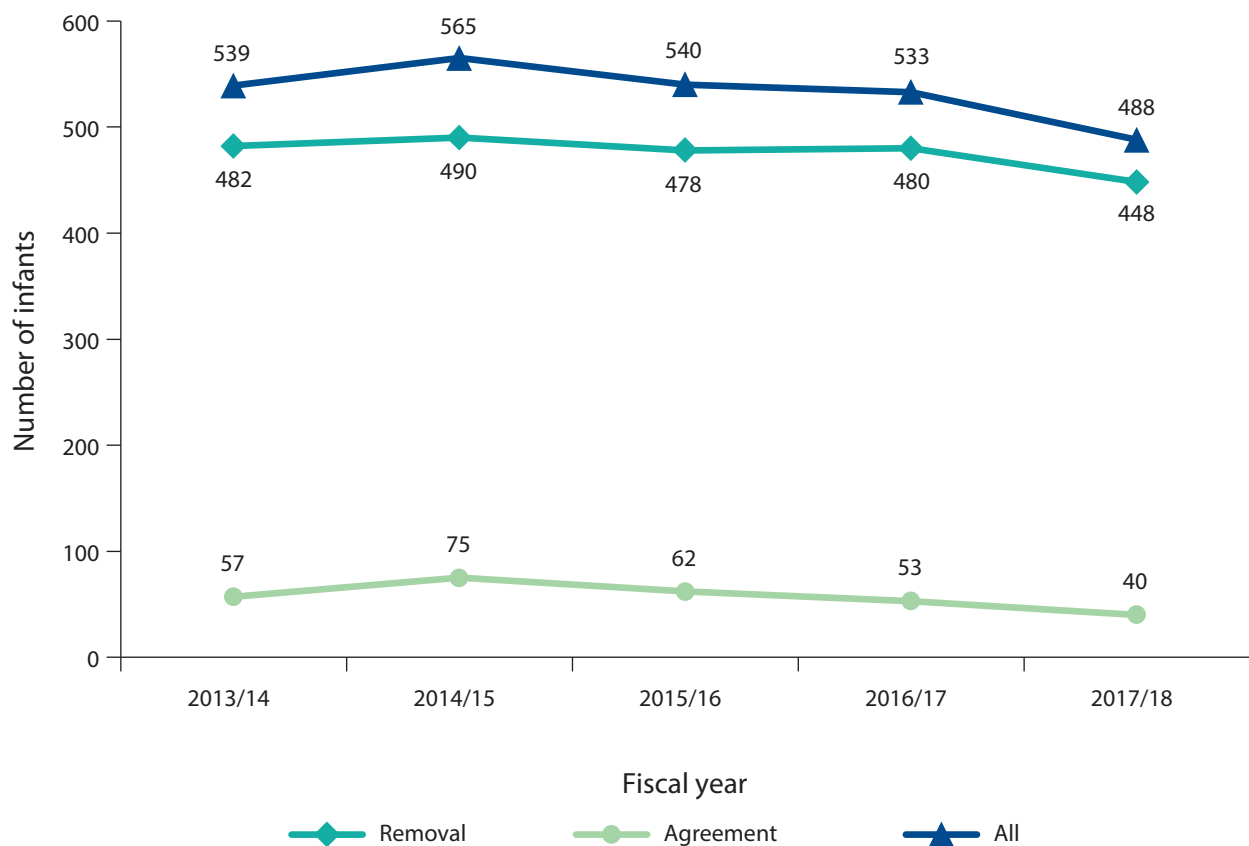
Looking at the Data

In order to understand the number of infants who are impacted by being separated from their parents (either by removal or a VCA), and the number of Indigenous infants who are disproportionately impacted by this action, it is important to take a close look at the data collected by MCFD.

Infants under age one represented 20 per cent of all children and youth between the ages of birth and 18-years-old who were placed in care either by removal or under a VCA in 2017/18.

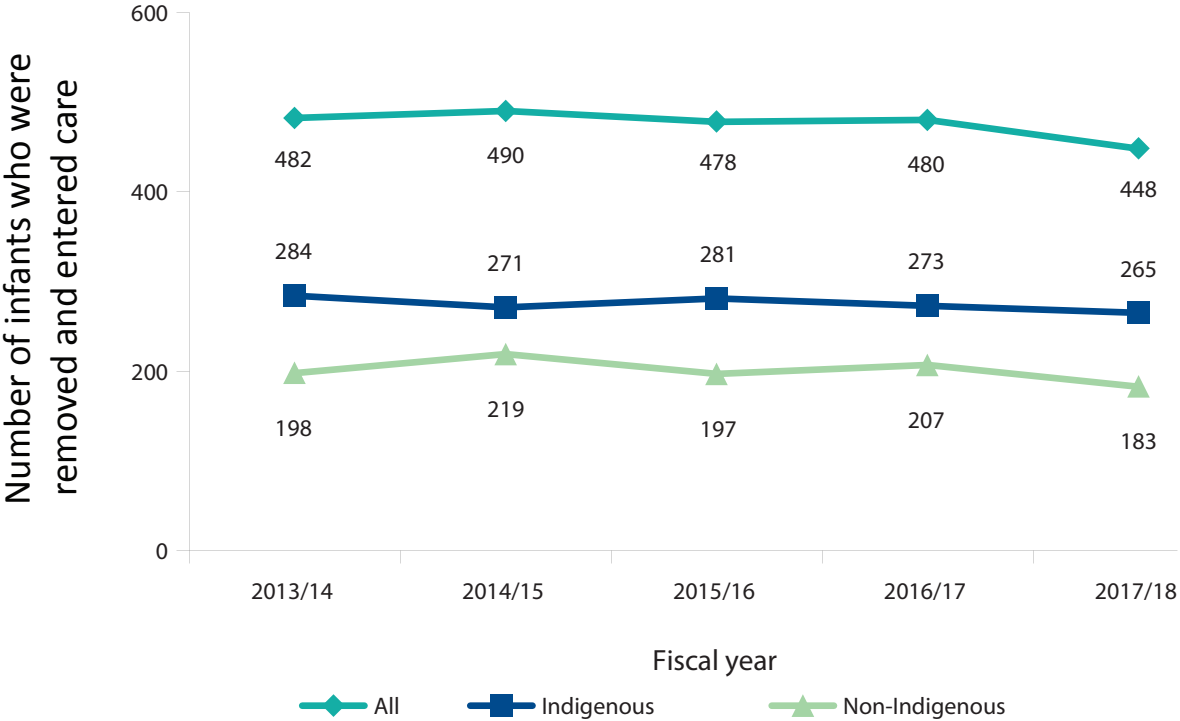
The figure below shows that substantially more infants entered care by removal within 12 months of birth than by VCA during a five-year period (2,378 versus 287).

Figure 1: The total number of infants who entered care by removal or VCA within 12 months of birth, 2013/14 to 2017/18 (based on the first entry to care)



Looking only at infants who were removed and entered care within 12 months of their birth, the figure below shows that a total of 2,378 infants in this category were removed between 2013/14 and 2017/18. Of these infants, a higher number were Indigenous than non-Indigenous. For example, in 2017/18, 448 infants were removed at less than 12-months-old, and of those, 59 per cent were Indigenous.

Figure 2: Number of infants who were removed and entered care within 12 months of birth, by Indigenous status, 2013/14 to 2017/18

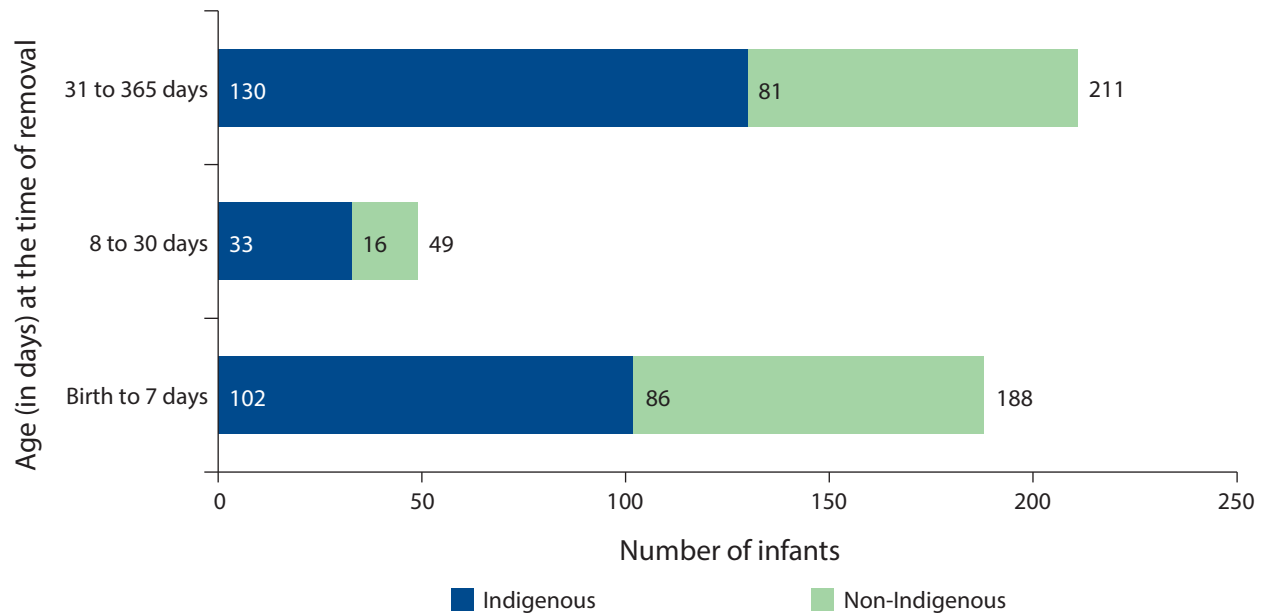


The figure below shows the age of infants (in days) and their Indigenous status at the time of their first removal during 2017/18.

Consistent across all age categories, a higher number of Indigenous infants entered care within 12 months of birth compared to their non-Indigenous peers.

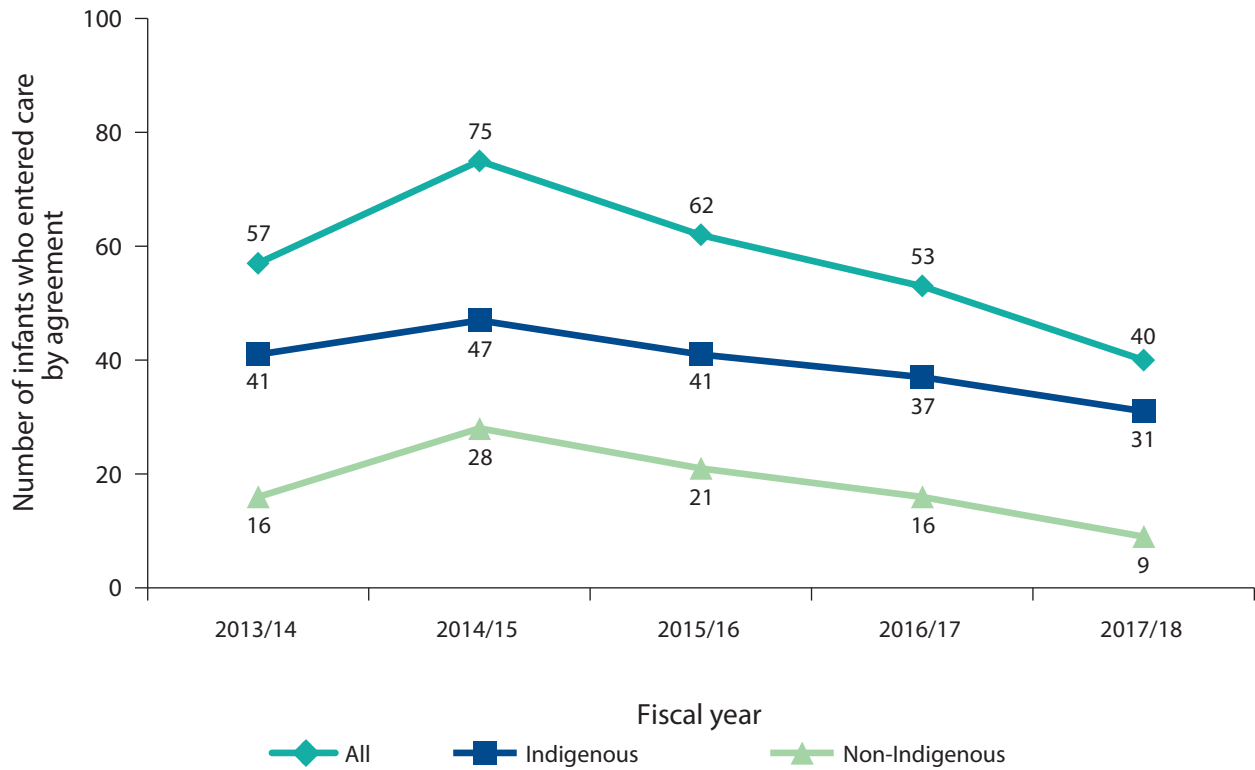
For both Indigenous and non-Indigenous infants, the most common reason for entering care through a removal was neglect. Among the subtypes of neglect, the most frequent reasons for entering care under a removal were when the parent was unable or unwilling to care for the infant (65 per cent) and cases involving neglect by a parent that included physical harm (19 per cent).

Figure 3: Number of infants who were removed and entered care within 12 months of birth by age of infant at the time of removal order and Indigenous status, 2017/18



Looking at infants who entered care by a VCA within 12 months of their birth for the five-year period 2013/14 to 2017/18 the data shows that over this period, the majority of these infants were Indigenous. For example, of the 40 infants who entered care by VCA within 12 months of their birth in 2017/18, 77.5 per cent were Indigenous while 22.5 per cent were non-Indigenous.

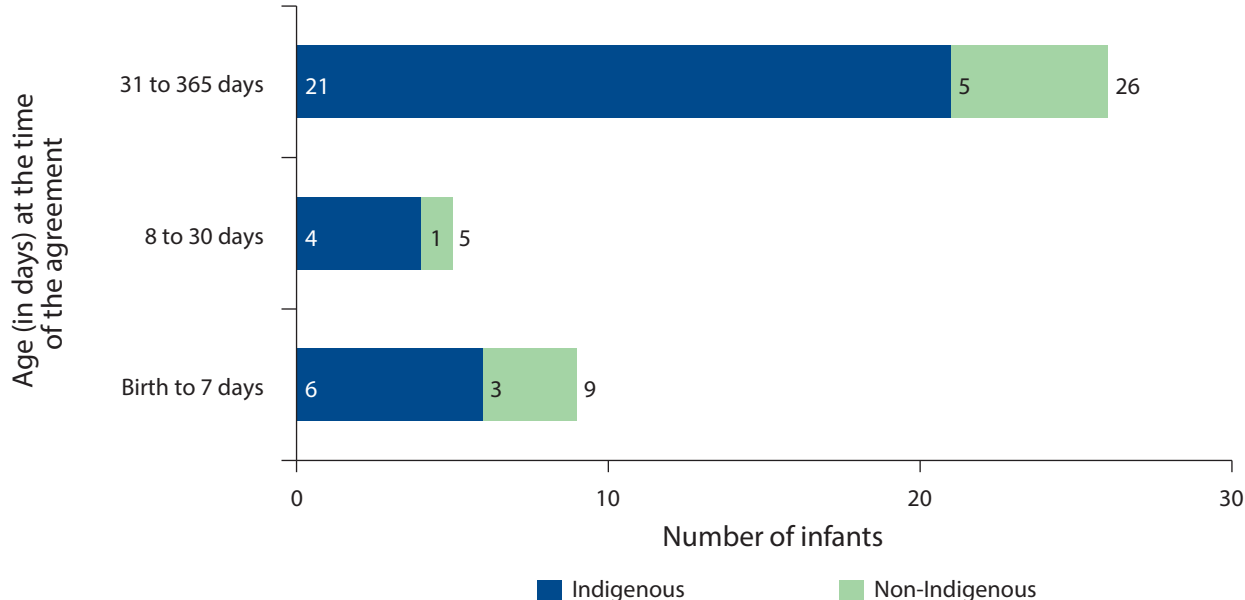
Figure 4: Number of infants who entered care by VCA within 12 months of birth, by Indigenous status, 2013/14 to 2017/18



The figure below illustrates how old the infants were (in days) when they first entered care through a VCA. The figure shows that across each age category, a higher number of Indigenous infants entered care by VCA compared to non-Indigenous infants.

For both Indigenous and non-Indigenous infants, the most common reason for entering care by VCA was neglect.

Figure 5: Number of infants who entered care within 12 months of birth by a VCA – by age of infant and Indigenous status, 2017/18



Literature Review

Rights-Based Literature

For social workers who work in child protection, the *United Nations Convention on the Rights of the Child (UNCRC)* is an overarching framework that should help to guide practice. The UNCRC was adopted in 1989 and ratified by Canada in December 1991.

- Article 3 of the UNCRC states that, *“In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.”*
- Article 9 of the UNCRC provides that, *“State Parties shall respect the right of the child who is separate from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child’s best interests.”*
- Article 24 of the UNCRC notes that, *“State Parties recognize the right of the child to the enjoyment of the highest attainable standard of health”* and, *“states should take appropriate measures to combat disease and malnutrition.”*

Researchers in Australia have considered breastfeeding in the context of families involved in child protection services and in relation to the UNCRC rights referenced above. They note that the Australian High Court ruled in 2003 that when the state is intervening in a family’s life and the case against the parent(s) has yet to be established, *“the very least the state can do is to make generous arrangements for contact.”*² The court continued that these arrangements must not be thwarted by a lack of resources but rather must be determined by the family’s needs. The ruling specifically mentions that nothing less than breastfeeding *“will meet the imperative demands of the Convention (UNCRC).”*³

² Karleen D. Gribble and Morgan Gallagher, “Rights of Children in Relation to Breastfeeding in Child Protection Cases.” *British Journal of Social Work*, vo. 44 (2014): 434-450 –qu. 439

³ Gribble, p. 439

Child Welfare–Specific Literature

In her paper “*Rights of Children in Relation to Breastfeeding in Child Protection Cases*,” Karleen Gribble acknowledges the complexity of social workers’ tasks when considering the best interests of children.⁴ Where breastfeeding is involved, she suggests the following three ways that child protection authorities might support children’s rights in relation to breastfeeding:

- create policies that reflect the rights of an infant with regard to breastfeeding
- always consider options for co-locating the mother and infant during child protection investigations, and
- where physical separation must happen, do everything to encourage breastfeeding, provide an electric breast pump and appropriate accessories, ensure the transport of the breastmilk to the infant, provide support for breastfeeding to the mother, and educate the caregiver on the importance of supporting breastfeeding.⁵

In addition, a study using Australian data asked the question: Does breastfeeding protect against substantiated child abuse? A 15-year study was undertaken of 512 children with substantiated maltreatment reports to attempt to answer this question. The study concluded that while breastfeeding duration is only one factor of many that may be associated with maternal abuse and neglect, breastfeeding may be a possible protective factor against maternal neglect.⁶

During 2009 and 2010, a Canadian study of mothers who use illicit drugs was conducted in Vancouver. Among other questions, 31 mothers were asked about opportunities for “*breastfeeding, holding and developing attachment*.” Only 26 per cent of the mothers said they had the opportunity to bond with their infants and only 19 per cent mentioned breastfeeding. Where mothers knew that there was no likelihood of gaining custody of their baby, or that the baby was to enter foster care, bonding was not pursued. The participants had access to specialized services such as housing, psychosocial services, social workers, food and practical supports, and also lived on the Downtown Eastside. Accessing these services resulted in a reduction of homelessness from 35.5 per cent to 9.7 per cent after their infants were born.⁷

⁴ Karleen D. Gribble and Morgan Gallagher, “Rights of Children in Relation to Breastfeeding in Child Protection Cases.” *British Journal of Social Work*, vo. 44 (2014): 434-450

⁵ Karleen D. Gribble and Morgan Gallagher, “Rights of Children in Relation to Breastfeeding in Child Protection Cases.” *British Journal of Social Work*, vo. 44 (2014): 434-450 –p. 445

⁶ Lane Strathearn et al., “Does Breastfeeding Protect Against Substantiated Child Abuse and Neglect? A 15-Year Cohort Study.” *National Institutes of Health, Pediatrics*, no. 132 (2009): 483-493.

⁷ Reinhard Krausz, “Addiction in Maternity: Mixed Methods Study on Substance Use During Maternity, Access to Services and Perceptions of Addiction in Maternity.” *Centre for Health evaluation and Outcome Sciences, University of British Columbia* (2010)

Indigenous-Specific Literature

Women and families who are involved with child protection services during pregnancy, birth and the post-partum period are disproportionately poor and Indigenous. *The Truth and Reconciliation Commission of Canada: Calls to Action*, in the Child Welfare section, calls upon all levels of government to “commit to reducing the number of Aboriginal children in care by ‘Providing adequate resources to enable Aboriginal communities and child-welfare organizations to keep Aboriginal families together where it is safe to do so, and to keep children in culturally appropriate environments, regardless of where they reside.’”⁸

*“All the rivers of the earth
are milk that comes from the
breast of the Great Mother.
Our breasts give the waters of
life to feed the children.”*

– ChoQosh Auh'Ho'oh, Elder

In Canada, the National Aboriginal Council of Midwives (NACM) conducted a situational analysis to consider Indigenous midwifery and to inform opportunities for future direction.⁹ Midwives are noted to have been part of Indigenous life prior to colonization, and the resurgence of Indigenous midwifery is pivotal to providing culturally safe health care services to women. NACM notes that returning birth (and thus breastfeeding) to communities is “critical to Indigenous people’s health ... restoring skills and pride in communities.” The resurgence of Indigenous midwifery is consistent with the movement in Indigenous communities across B.C., who are acting to end the removal of their children by offering support and less disruptive measures to enable children to remain with their parents and/or in their communities.

Breastfeeding: Health and Social Benefits

Breastfeeding is universally known to be the optimum way to feed infants. The World Health Organization, United Nations Children’s Emergency Fund (UNICEF), the Public Health Agency of Canada, Health Canada, the Canadian Paediatric Society (CPS) and the B.C. Ministry of Health all recommend that infants be fed breastmilk exclusively for the first six months of their lives. Breastfeeding with complementary foods can be continued to age two and beyond.¹¹

*“Human milk is the epitome
of individualized medicine –
each mother makes milk that
is specific to her baby’s needs
at any particular time.”*

– Natasha K. Sriraman¹²

⁸ “Truth and Reconciliation Commission of Canada: Calls to Action,” Winnipeg (2015), p. 1.

⁹ “Rooted in Our Past Looking to Our Future,” *National Aboriginal Council of Midwives*, 2017.

¹⁰ Natasha K. Sriraman, “The Nuts and Bolts of Breastfeeding: Anatomy and Physiology of Lactation.” *Current Problems in Pediatric and Adolescent Health Care*, no. 47 (2017), 309.

¹¹ World Health Organization, <http://www.who.int/topics/breastfeeding/en/>, UNICEF, https://www.unicef.org/nutrition/index_24824.html, PHAC, <https://www.canada.ca/en/public-health/services/health-promotion/childhood-adolescence/stages-childhood/infancy-birth-two-years/breastfeeding-infant-nutrition.html>, CPS, <https://www.cps.ca/en/documents/position/nutrition-healthy-term-infants-overview>, HealthLink BC, <https://www.healthlinkbc.ca/health-topics/hw91687>

Colostrum, the first milk produced by a mother after birth is uniquely complex and provides essential immunological protection for an infant, is especially high in nutritional value and is well documented to reduce infants' risk of developing several inflammatory diseases such as asthma.

The CPS endorses breastfeeding, noting, *"It is universally accepted that breast milk is the optimum exclusive source of nutrition for the first six months of life"* and that, from a nutritional perspective to date, the complexity of *"bioactive"* benefits cannot be replaced by formula. Further, CPS states that breastfeeding is a *"critical public health initiative"* with significant advantages to mothers and infants in terms of health, social and economic outcomes.¹²

While it is generally assumed that breastfeeding enhances the maternal infant bond, much of the literature concludes that there is no empirical evidence that this is the case. The quality of the attachment bond is predicated on the quality of the maternal infant relationship rather than the method of feeding.¹³

Breastfeeding Special Circumstances: Opiates

The literature is clear that breastfeeding is safe and of benefit to infants where the mother is taking opioid agonist therapy when the infant is born close to term and is medically stable. In the research paper "Breastfeeding and Opiate Substitution Therapy: Starting to Understand Infant Feeding Choices," American and Canadian researchers detail that few women on opioid agonists breastfeed, in spite of its safety, likely due to societal stigmas and a lack of health-care provider information and education to the mothers.¹⁴ The paper details that both methadone and buprenorphine substitution therapy are safe while breastfeeding and reduce neonatal withdrawal symptoms.

Both the Academy of Breastfeeding Medicine and the American Academy of Pediatrics support breastfeeding in these contexts. Lacaze-Masmonteil and O'Flaherty's paper on managing the effects of withdrawal on infants born with opioid dependency suggests that opioid-dependent mothers should stay with their infants (rooming-in) when the infants are stable, to support breastfeeding initiation rates and early attachment.¹⁵ The paper notes that breastfeeding *"should be encouraged"*

Opioid agonist therapy is a harm-reduction method for treatment of addiction to opioid drugs (e.g. heroin, fentanyl, and oxycodone) by using an opioid agonist (methadone and buprenorphine) to prevent withdrawal and reduce cravings for opioids.

¹² "The Baby-Friendly Initiative: Protecting, promoting and supporting breastfeeding," Canadian Pediatric Society, last modified Jan. 30, 2017, accessed May 21, 2018, <https://www.cps.ca/en/documents/position/baby-friendly-initiative-breastfeeding>.

¹³ John R. Britton and Helen L. Britton, *Breastfeeding, Sensitivity and Attachment* (Tuscon: University of Arizona Health Sciences Center, 2006)

¹⁴ Lisa E. Graves and Suzanne Turner, "Breastfeeding and Opiate Substitution Therapy: Starting to Understand Infant Feeding Choices. Substance Abuse: Research and Treatment," *Libertas Academia*, no.10 (2016): 43-47.

¹⁵ Thierry Lacaze-Masmonteil and Pat O'Flaherty, "Managing Infants Born to Mothers who have used Opioids during Pregnancy," *Pediatrics & Child Health*, vol. 23, no. 3 (2018): 220-226.

as part of the management of infants exposed to opioids as it can “*delay the onset and decrease the severity of withdrawal symptoms.*”¹⁶

Breastfeeding Special Circumstances: Human Immunodeficiency Virus (HIV) and Hepatitis C

The most recent Canadian HIV guidelines for pregnancy and breastfeeding include the fact that mother-to-child transmission risk is less than one per cent due to excellent prenatal care, including HIV therapies. However, the use of formula rather than breastfeeding is recommended, as HIV can be transmitted via breastfeeding.¹⁷

Maternal Hepatitis C infection appears to not be transmitted through breastmilk. It is generally considered safe to breastfeed for mothers with Hepatitis C, should they wish to do so.¹⁸

Breastfeeding Special Circumstances: Milk Banking

Where a mother may not be able to directly breastfeed, options for expressed breastmilk (EBM) for her infant include milk banking, which is becoming more readily available. This can include milk banks in hospitals that provide donor breastmilk or the mother’s own EBM for her infant. Milk processing follows the Human Milk Banking Association of North America guidelines, and in Canada the processing of human breastmilk is subject to Health Canada regulations for food substances and regular inspections by the Canadian Food Inspection Agency. BC Women’s Hospital operates a provincial milk bank and has provided sick and/or premature infants with donated breastmilk since 1974. Donor milk is available at three sites: BC Women’s, Royal Columbian and Surrey Memorial Hospitals.¹⁹ Plans are underway to make this service available to more Neonatal Intensive Care Units in the province.

When a mother wishes to provide EBM for her infant, guidelines exist for the safe handling of EBM. This practice may be particularly useful when a mother cannot access her infant, where access is limited or where other reasons exist for not being able to directly breastfeed.²⁰

¹⁶ Thierry Lacaze-Masmonteil and Pat O’Flaherty

¹⁷ “New Canadian HIV Guidelines for planning pregnancy,” CATIE, last modified June 21, 2012, accessed on May 31, 2018, <http://www.catie.ca/en/catieneews/2012-06-21/new-canadian-hiv-guidelines-for-planning-pregnancy>.

¹⁸ “Hepatitis C in the Perinatal Period, Obstetric Guideline 18,” *British Columbia Reproductive Care Program, 2003*.

¹⁹ “BC Women’s Provincial Milk Bank,” accessed on May 20, 2018, <http://www.bcwomens.ca/our-services/labour-birth-post-birth-care/milk-bank>.

²⁰ HealthLink BC, “Storing Breast Milk,” last modified on May 12, 2017, accessed on May 30, 2018, <https://www.healthlinkbc.ca/health-topics/ue5301>

Jurisdictional Scan

Canada

A jurisdictional scan was conducted across 13 provinces and territories in April 2018 by the Provincial and Territorial Directors of Child Welfare Committee. The purpose of the scan was to obtain information on policy or practice standards, resources and residential services that support the promotion of breastfeeding between a mother and infant when the infant has been removed.

In this scan, nine out of 13 provinces and territories responded to the request for information. The scan revealed that, across these provinces and territories, there is no specific policy that addresses breastfeeding after an infant has been found in need of protection and removed from a mother's care.

Many of the provinces had supports and resources available to facilitate the emotional and physical care needs of a child. For example:

- B.C.'s Nurse-Family Partnership (NFP) – a free public health program for women having their first baby. Public health nurses visit young women who are preparing to parent for the first time. Aimed at mothers whose circumstances place them at risk for vulnerability, the program provides home visits and intensive supports until their child's second birthday. NFP starts prenatally, allowing it to influence child development right from the start. The program supports healthy pregnancy, preparation for childbirth, nutrition (including support for breastfeeding), exercise, parenting, child development, future life planning and accessing community resources.
- Alberta's Vulnerable Infant Response Team – nurses are attached to infants three-months-old and under who may be at risk. The nurses provide parenting skills, mental health and breastfeeding support to a mother. This model of support is under development as a province-wide program.
- Saskatchewan's Moving Families Forward program – provides intensive pre- and post-partum supports to women with addiction issues. Staff work closely with a breastfeeding parent on prevention and education about the impact of substance use on breastfeeding.

When a child protection authority is involved in the removal of an infant, some of the common themes of supporting the breastfeeding mother found in the jurisdictional scan included: encouraging ways to make breastmilk available to an infant; transporting breastmilk to foster homes; facilitating breastfeeding at mother visits; purchasing breast pumps; and residential outreach services that also have a focus on addiction support.

Residential models of support are another way to ensure a mother-infant connection while addressing any risk factors. Table 1 offers some examples.

Table 1 – Residential Models of Support: Provincial Examples

Province	Residential Model of Support	Description
British Columbia	Her Way Home	Provides in-home support for pregnant and parenting women who have a history of substance use
Alberta	Healthy, Empowered, Resilient	Provides accommodation and supports to vulnerable pregnant women up to six months after birth
Nova Scotia	Supported Housing for Young Mothers	Assists young mothers to develop skills to parent independently

Overall, the result of the cross-Canada jurisdictional scan indicates that there are no policies or guidelines for practitioners in child protection to follow that specifically support the promotion of breastfeeding between a mother and infant when the infant has been removed. However, many provincial authorities do have programs and services to facilitate breastfeeding and bonding.

New Zealand

UNICEF’s Baby Friendly Initiative in New Zealand, partnering with the Ministry of Health, operates a broad campaign to increase the frequency of breastfeeding among new mothers across the country.

Related to child welfare and removal, New Zealand references breastfeeding within an overarching policy to maintain an infant’s connection to his or her biological mother and extended family. This policy states:

“When mokopuna cannot live at home it is important that they have meaningful contact with their family/whānau. Family/whānau will be part of their life forever, and they need to have safe and nurturing contact with family/whānau who can help them understand who they are and their place in the wider family/whānau system.”

Child welfare policy in New Zealand does not provide specific guidance on breastfeeding.

Review of RCY Advocacy Cases

The Representative's Office reviewed 110 advocacy files for the 5 ½ -year period from early 2013 to mid-2018 that involved breastfeeding mothers. The purpose of the review was to determine if there were common case management themes or challenges that affected best practice in service delivery to families where MCFD or a Delegated Aboriginal Agency (DAA) were involved. The key challenges identified were:

- Methadone/substance use – some files involved mothers who were on a methadone management program or using substances and social workers were faced with differing medical opinions about the safety of breastmilk in these cases.
- Domestic violence – some files involved parents with a history of domestic violence in the family home. When an infant is found in need of protection and needs to be removed from the parents' care, MCFD or the DAA will consider safe options available to facilitate breastfeeding. In some cases, this resulted in interruptions to breastfeeding as time was needed to assess current risk and to plan appropriately.
- Cultural views specific to Indigenous families – many files involved Indigenous families where cultural considerations around access and breastfeeding were not always apparent or considered in planning.
- Inconsistent pre-birth planning – many of the files involved parents who felt that MCFD or the DAA had not engaged with them in pre-birth planning to allow sufficient access for bonding and breastfeeding. One challenge in doing so is that there is no legal mandate to provide services without consent prior to the birth of a child; therefore, parental participation in services before an infant is born is voluntary.
- Supervision/access issues to facilitate breastfeeding – some files involved parents whose infant had been removed and MCFD or the DAA had agreed to provide supervised access to facilitate breastfeeding but encountered challenges increasing access time and finding supervision for visits. Parents also described situations where the mother pumped her breastmilk so the baby could receive it from the caregiver but MCFD or the DAA could not provide delivery services.

Overall, the review of the 110 RCY cases clearly illustrated the many challenges to facilitating breastfeeding when child protection concerns exist. Most families indicated that they were significantly affected by the lack of early planning or immediate planning by MCFD or the DAA to facilitate breastfeeding. Families felt it should be a priority to engage as soon as possible with family and extended family to create an access plan to facilitate breastfeeding. Extended family could include parents, grandparents, aunts, uncles, cousins, trusted friends and neighbours. The families felt that

A shelter (following page) refers to transitional housing for women who are pregnant or have a newborn and need a safe place to stay. Most shelters have skilled staff attached and can provide supports such as emotional support, parenting support, advocacy, child care and help connecting to other resources. This can often serve as a planned alternative to the infant being removed at birth and provide the parent the opportunity to parent with support.

it would be more natural to create a plan with family or extended family to facilitate the access to breastmilk and bonding with the infant. This would promote the infant's best interests and support safety and follow-through by all parties. Creating solid safety plans can mitigate the risks to the infant and support the family in working toward reunification.

Some of these cases also highlight the need for a more supported housing or shelter model that would provide a safe and supported environment with skilled caregivers for mother and infant.

Case Study #1

Community Supports Playing a Critical Role – Betty's Story

Betty was a 20-year-old mom to baby James. The local DAA became involved with this family when it learned that Betty was pregnant and parenting support would be required to mitigate risk to the infant. Betty had shared that she was concerned her current living situation was not suitable or safe for a newborn and MCFD had some concerns due to a history of drug use. Betty had been connected to supports during her pregnancy and was on the methadone maintenance program. A pre-planning meeting occurred with the social worker, parents and other professionals shortly before James was born to discuss planning and develop a safety plan. The safety plan indicated that Betty would move into supportive housing with her newborn. James was born a week later. Several meetings were held at the hospital as hospital staff had concerns about James' health and the parents' capacity to care for him.

The DAA social worker decided that the current safety plan was no longer adequate to protect James because the shelter could not provide the necessary supports. Because no less disruptive measures were available, James was removed from his parents' care and placed in a foster home. Initially, access was twice a week for 1 ½ hours. Betty made a request to the social worker to be able to breastfeed James daily. RCY provided advocacy around James' access to his parents and breastfeeding. Betty pumped and froze her breastmilk between access visits. Because Betty was using marijuana and methadone, the social worker consulted with a physician who confirmed that there was no risk for James to receive his mother's breastmilk.

Roughly a week later, during a visit with the social worker, concerns were raised about the baby's physical health, as he was seen "twitching." James was seen by a pediatrician, who was concerned about the inconsistency in the breastfeeding and that Neonatal Abstinence Syndrome withdrawal would happen if Betty was to start and stop breastfeeding James. It was decided that the breastfeeding would be discontinued until James was returned to his mom's care. Access visits gradually increased and baby James was returned to his mother's care under a Supervision Order.

Case Study #2

Interruptions in Breastfeeding – Cindy's Story

Cindy was the mother to 11-year-old Sam and infant Vince. There was a history of domestic violence between Cindy and Vince's father and there was a no contact order between the parents at the time of Vince's birth. When Vince was born, his father came to see Cindy in the hospital. MCFD became involved with this Indigenous family and Cindy was advised that MCFD intended to remove the children from her care because she allowed Vince's father to visit. Cindy agreed to a safety plan and each child stayed with extended family.

Initially, Cindy had overnight visits with Vince and breastfed him. Overnight visits were stopped due to additional concerns and Vince was removed from his mother's care. However, Cindy continued to have access to him during the day. MCFD received additional child protection reports and all access between Cindy and Vince ended. Cindy was very concerned that Vince had been bottle fed for 16 days and despite pumping her breastmilk (with little success), she was concerned that she would not be able to directly breastfeed when access was reinstated. After RCY involvement, access was reinstated at twice a week and with supervision. Unfortunately, Cindy was no longer able to breastfeed as her milk supply had dried up.

Case Study #3

Managing Multiple Challenges – Josephine's Story

Josephine was a client of Community Living British Columbia (CLBC) and living in a home share where she was supported with basic life skills such as cooking, budgeting and time management. She was 21-years-old when she gave birth to her daughter, Cloe. MCFD was notified of Josephine's pregnancy seven months prior to the birth. Pre-planning meetings occurred between MCFD, CLBC and local service providers before Cloe's birth and a plan had been drawn up with two options:

1. Upon discharge from hospital, Josephine would maintain guardianship and take Cloe home, staying with her home share provider.
2. Upon discharge from hospital, Cloe would be removed and placed in the home share provider's care and Josephine would be able to remain there. The home share provider would assume a dual role, foster parent and CLBC caregiver.

After Cloe was born, she was removed from Josephine's care and placed into a different foster home because MCFD believed that the home share provider would be unable to balance providing services to both Josephine and Cloe. At the time of the removal, MCFD permitted Josephine to have daily visits with Cloe; however, these visits ended up being just once per week for three hours at a time. This schedule did not permit regular breastfeeding opportunities and no alternative arrangements were made for Cloe to receive Josephine's breastmilk. An RCY advocate became involved three weeks after Cloe's birth. Several weeks after RCY's involvement, Josephine's home share placement broke down. The issue of breastfeeding was never resolved and Cloe was placed under a Continuing Custody Order by consent and later placed with family. This case illustrates the need for more rigorous pre-birth planning.

Promising Practices

When looking at changing practice to improve the lives of children and families, reviewing promising practices already in place can inform and improve service delivery on a larger scale. B.C. and Alberta provide three examples of programs that support the mother/infant bond through breastfeeding.

"Mother the mother and you will mother the child"

– Ainsley McCaskill²³

Fir Square Combined Care Unit

Fir (Families in Recovery) Square Combined Care Unit opened in 2003, located in BC Women's Hospital and Health Centre in Vancouver. Fir Square provides perinatal care for women with problematic substance use and their exposed newborns by assisting women and their newborns to stabilize and withdraw from substances. The mother/infant partnership is kept together during their Fir Square stay while the mother works with community partners to facilitate remaining with her infant after discharge, where possible. An interdisciplinary team – including physicians, specialized nurses, a social worker, an Indigenous Elder in Residence, addictions counsellor, pharmacist, nutritionist, recreational and art therapist, spiritual carers, legal aid and a BC Housing and Health Coordinator – support the duo in a continuum of care.

Fir Square

12 beds with overflow in maternity beds where those women attend Fir Square programming:

- Occupancy Rate: 97.6 per cent
- 2016/2017: 151 women and 103 infants served
- Average length of stay: 30.7 days
- Rooming-in significantly reduces the need to treat withdrawal in the newborn
- 85 per cent of women were on opioid agonist therapies; reduced to 14 per cent when rooming-in with infant.

Prior to the opening of Fir Square, infants were removed from women in this cohort 100 per cent of the time. Currently, Fir Square's articulated goal is to be an *"apprehension free"* space providing robust support in the form of neonatal management (rooming-in), addiction management and obstetric management all in a trauma-informed and culturally safe way while understanding the social inequities and stigmatization that these women face.

Sheway

The Sheway program is located in the Downtown Eastside of Vancouver and is a community-based Pregnancy Outreach Program (POP) for women and children. Sheway provides health and social service supports to pregnant and parenting women with children under age five and who have current or historical substance use. The goal is for women to have choice in their care and to promote healthy pregnancies and positive early parenting. This is achieved by working collaboratively

²¹ Ainsley McCaskill, Perinatal Addictions, Hand Out, Fir Square, BC Women's Hospital.

in partnerships and providing a “one-stop shop” for women and their children. A full medical clinic, a daycare (Crabtree Corner operated by the YWCA), a drug and alcohol counsellor, daily hot lunches, grocery supports, practical support for securing housing and social benefits, parenting support, First Nations Support Workers, Elders in Residence, social workers and medical professionals are all available on site. The YWCA also operates a residential space of 12 supported housing beds that are co-located in the building.

Both of these B.C. programs – Fir Square and Sheway – while distinct, share some fundamental philosophies and practices which are unique and have commendable outcomes. Both consider the pregnant mother or mother and infant as a team and support the mother to achieve better health for herself and her infant. Both programs work with mothers who use substances or have used substances. Neither program is in support of the removal of an infant from its mother for reasons such as trauma, inequity, homelessness or substance use. Each works to destigmatize these women and remove barriers for them to attain their goals. Each has created a place of safety for women and children, thereby disrupting the cycle of child apprehension and hopelessness that has characterized many of these women’s lives. Together, Fir Square and Sheway respond to systemic barriers in an integrated and multidimensional way to provide space for stabilization of the mother/infant team, which creates the possibility for change.

Sheway is a Coast Salish word that means “*growth*.” In both of these unique programs, women and their children are experiencing growth and success as they are given the chance to room-in with their infants, breastfeed if they desire, and parent, all of which have been historically (and contemporarily in most jurisdictions) denied them.

Sheway Pregnancy Outreach Program

- Approximately 80 per cent of women who access services have lived in foster care type arrangements.
- In 2012/13, 74 per cent of children were in the care of their parent/s while 24 per cent were in foster care. This contrasts with 1993, when 100 per cent of infants born to substance using mothers were apprehended.
- In 2016/17:
 - 331 women and 329 children received services through Sheway
 - 35 per cent of clients were on opiate replacement therapy
 - hot lunches were provided to 1,132 clients per month
 - 150 outreach visits attempted to engage and advocate for clients
 - 60 per cent of infants left the hospital in their mother’s care and 90 per cent remain in their mother’s care.

A Provincial Model: Alberta PCAP

The Parent-Child Assistance Program (PCAP) was developed at the University of Washington in 1991 as an evidence-based demonstration project aimed at the prevention of alcohol and drug exposed births. PCAP is a three-year home visitation program that partners a mentor with a high risk mother. The mentor supports the client to achieve her self-determined goals by creating relationships with community service providers. The PCAP program is in many ways similar to B.C.'s Sheway and Fir Square programs in terms of working with high risk substance using mothers to promote healthy pregnancies, healthy births and positive parenting.

In 1999, three PCAP programs operated in Alberta. Today 30 programs operate across the province located in urban centres, remote communities and First Nations communities. Typically, more than 600 women are served each year. The Alberta PCAP Council is a non-profit board that supports PCAP programs in the province to operate in an educated, culturally safe, thoughtful and efficient manner that is consistent with the Alberta PCAP model. Although considerations such as geographic isolation, location, availability of other resources and number of staff members has led to variations among programs, PCAP core training and other provincial supports contribute to conformity to the model and the success of PCAP in Alberta.

Funding is provided mainly by the Alberta FASD Cross Ministry Committee with representatives from the Ministries of Education, Community and Social Services, Children's Services, Enterprise and Advanced Education, Health, Aboriginal Relations and Justice and Solicitor General.

First Nation Inuit Health Branch has been funding seven First Nation PCAPs since 2006, and in 2015, Alberta Health provided funding for six additional PCAPs in First Nation communities.

PCAP and Child Welfare Involvement

- At intake, about half of the women served by PCAP had an open case with Children's Services (CS) at some point in the previous three years, and more than half of the women had involvement with CS after the birth of the target infant.
- Throughout the program there is a small decrease in the number of women who accessed CS and an increase in the number of women who did not require CS services.
- PCAP mentors work closely with the community service providers who work with the women. Mentors help the women create action and safety plans, which could support their CS requirements. Mentors also encourage women to connect and communicate honestly with CS, building trust between the women and their CS worker.
- After the target infant's birth, 76 per cent of women had legal custody of their infant, 17 per cent of the infants were in the custody of the Director, two per cent were in the custody of the father or other relative, and two per cent were in the custody of legal guardianship.

Huu-ay-aht First Nations Social Services Project: Safe, Healthy and Connected, Bringing Huu-ay-aht Children Home

Huu-ay-aht First Nations on Vancouver Island recently received federal and provincial government funding to begin implementing 30 recommendations made by its independent Social Services Panel in 2017. Of these recommendations, Huu-ay-aht has made Recommendation 26 one of its top priorities: working to establish a centre to keep families together. The need for prompt action to provide safe housing and resources has been a strong message from the Huu-ay-aht community. Building from models for social services homes that provide single-site programming and safe housing for Indigenous families – such as the Vancouver Aboriginal Mothers Centre and similar centres established by the Seabird Island and Sts'ailes First Nations – Huu-ay-aht aims to open a home in Port Alberni for services and families in the near future. Huu-ay-aht sees this as an important step toward minimizing harmful disruptions that separate Huu-ay-aht children and families.

Conclusion

In the context of child welfare matters, when an infant is removed from its birth mother, the infant is generally deprived of his or her right to the nutritional benefits of breastmilk, which research shows has a long-term impact on healthy development. Research also shows that breastfeeding promotes attachment, which similarly plays a positive role in a child's development.

MCFD and RCY undertook this review of existing policies and practice in B.C. and other jurisdictions with a shared goal of strengthening families' capacity to care for infants and potentially prevent the removal of infants from their birth mothers. To understand the present situation and to consider less disruptive measures for families, it was necessary to review MCFD data and relevant RCY advocacy cases. It is evident from this work that the role of extended family and communities must be considered as crucial supports that can keep mothers and infants together.

The over-representation of Indigenous children and youth in care begins with the decision to bring a child into care in the first place. It is therefore imperative that practices that result in fewer children entering care are considered and implemented in B.C.

While each situation that arises is unique, and it is complex to balance an infant's right to nutrition and connection with his or her right to safety, MCFD and RCY are in agreement that guidelines must be in place and steps must be taken to promote family unity wherever possible. In the longer term, it is clear that this is in an infant's best interests.

Action Plan

As a result of this review, MCFD has committed to the following actions:

1. MCFD will review and update its *Practice Directive on Working with Expectant Parents with High Risk Behaviours* with respect to considering additional practices and guidelines for social workers to plan with families to help mothers and their infants remain together, including the role of extended family and communities in supporting mothers and infants.
 - **To be completed by September 30, 2019.**
2. MCFD will develop guidelines for social workers to promote breastfeeding in circumstances in which infants have been removed. These would include: facilitating breastfeeding by mothers; ways to make breastmilk available to the infant; breastfeeding and substance use; and, purchasing breast pumps.
 - **To be completed by March 31, 2019.**
3. MCFD will research promising practice models of supportive housing alternatives in which both mothers and their infants at risk can be placed, and will develop a plan for implementation of those resources.
 - **To be completed by September 30, 2019.**
4. The Ministry of Health and the Ministry of Mental Health and Addictions will work with MCFD and Indigenous partners to continue to increase access to evidence-based programs that provide prenatal and post-partum care for women who use substances and to their infants exposed to substances.
 - **To be completed by March 31, 2019.**
5. MCFD and RCY will explore policies and practices to improve access to RCY advocacy services including:
 - RCY'S advocacy outreach initiatives will target stakeholders who provide services to expectant mothers.
 - In their review of Practice Directive noted in Action 1, MCFD will consider practices and guidelines for social workers to provide information to mothers, fathers and families about the role of RCY advocacy services on behalf of the expected child.
 - **To be completed by September 30, 2018.**

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