COVID-19 and Pregnant and Parenting Women Who Use Drugs: Exploring the Impact of Stigmatization on Help-Seeking Behaviour

by

Emily Nichol
Bachelor of Arts (Honours), McMaster University, 2017

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of

MASTER OF ARTS

in the Program of Social Dimensions of Health

© Emily Nichol, 2022
University of Victoria

All rights reserved. This thesis may not be reproduced in whole or in part, by photocopy or other means, without permission of the author.

We acknowledge and respect the lək̓ʷəŋən peoples on whose traditional territory the university stands and the Songhees, Esquimalt and W̱SÁNEĆ peoples whose historical relationships with the land continue to this day.

COVID-19 and Pregnant and Parenting Women Who Use Drugs: Exploring the Impact of Stigmatization on Help-Seeking Behaviour

Emily Nichol
Bachelor of Arts (Honours), McMaster University, 2017

Supervisory Committee

Dr. Karen Urbanoski, Department of Public Health and Social Policy
Supervisor

Dr. Bernie Pauly, School of Nursing
Co-Supervisor

Abstract

Stigma surrounding substance use has been documented as a roadblock to recovery, posing a greater barrier to care for some populations more than others. In particular, pregnant and parenting women are an often overlooked and understudied demographic who could benefit considerably from targeted resources. Though, due to stigma surrounding substance use and motherhood, this demographic is routinely subject to judgement and discrimination resulting in delayed treatment entry. In the midst of the COVID-19 pandemic, issues of access have been compounded by a reduction in services despite heightened mental health struggles caused by prolonged periods of isolation and abrupt changes in lifestyle and environment. The purpose of this study is to understand how stigmatization affects help-seeking behaviour and to explore the impact of COVID-19 on women's mental health and treatment experiences. Semi-structured telephone interviews were conducted from October 2020-February 2021, with current and past clients of integrated treatment programs in Ontario (n=24). Using an interpretive description approach, data was constructed to identify how stigma is internalized, anticipated, and embodied in the context of help-seeking behaviour, as well as to determine the extent to which the pandemic has interfered with maternal wellbeing. The following themes emerged: (1) stigma and help-seeking (2) COVID-19 and maternal wellness (3) stigma at the structural level: barriers to care and (4) mitigating stigma to enhance help-seeking: facilitating recovery through relationships. This research contributes evidence to a growing body of literature emphasizing the importance of relationships in the recovery process for combatting the effects of stigma and promoting early treatment entry and lends insight into the ways in which pregnant and parenting women with problematic substance use have navigated recovery during COVID-19.

Table of Contents

Acknowledgements

A special thanks to Dr. Milligan and her research team at Ryerson University for allowing me to conduct my study alongside the follow-up Parenting Study. Your guidance and expertise helped me grow as a researcher.

Thank you to my supervisors Dr. Karen Urbanoski and Dr. Bernie Pauly, whose patience has been much appreciated as I grappled with the setbacks of conducting research in a pandemic.

Thank you to my parents, Kathy and Paul; siblings, Ted, Laura, and brother-in-law Marc; as well as my extended family, for always providing a soft place to land.

And thank you to my closest friends, Hana, Priya, and Shak, whose love and support has spanned distance and time zones. The messages, phone calls, and compassion on the long nights means more to me than you know.

Dedication

For the women who so graciously shared their stories,

and for those whose stories have yet to be told

Chapter 1: Introduction

Study Population

Problematic substance use refers to the persistent consumption of alcohol or other drugs in a harmful manner, negatively impacting health and wellbeing (Health Canada, 2019). While rehabilitation programs, peer counseling, harm reduction services, and self-help groups all strive to support the general population, pregnant and parenting women who use drugs are an overlooked demographic with a unique set of needs and challenges. Research indicates that there are narrowing gender gaps concerning prevalence of substance use (Seedat et al., 2009; Steingrimsson at al., 2012) and alcohol use disorders (Keyes et al., 2008), and women are now represented in substance use treatment programs at higher rates than ever before, presenting with more severe medical, psychiatric, and social problems compared to men (McHugh, et al., 2014). The pervasiveness of co-occurring substance use and mental disorders is high; women often report anxiety, depression, and histories of trauma (Poole & Isaac, 2001). There is evidence of associations between intimate partner violence and subsequent problematic substance use, with reports of lifetime histories of physical, emotional, and sexual abuse resulting in substance use at rates higher than the general public (Cafferky et al., 2018; Campbell, 2002; Smith et al., 2010). A U.S.-based study by the National Centre on Addiction and Substance Abuse (CASA) (2003) identified emotional and relational pathways to tobacco, alcohol, and drug use for young women and girls, who reported using to: improve mood and/or self-esteem; cope with stress; lose inhibitions; enhance sex; and lose weight, heightening the risk of problematic use later in life.

On a structural level, women are subject to less social and economic capital compared to men, producing conditions that make it more difficult to access and keep safe housing and stable employment. In North America, more women live below the poverty line than men, with disproportionate rates among visible minority women, women with disabilities, single mothers, and LGBTQ women as well as those who identify as gender non-conforming (Badgett et al., 2019). More than just an issue of the gendered-wage gap (Pelletier et al., 2019), occupational segregation into low paying jobs (Miller, 2004) and a lack of supportive work-family policies (Olivetti & Petrongolo, 2017) constrain women's access to the social determinants of health, perpetuating conditions that lead to problematic substance use. With origins and patterns of use that differ from men, as well as challenges that must be overcome for upward social mobility, distinct treatment strategies are required to address women's needs in recovery through a holistic lens.

Statement of the Problem

Pregnancy has been described as a window of opportunity for treatment with increased motivation stemming from concern for the fetus (Milligan et al., 2011; Pool & Isaac, 2001). In order to enhance outcomes, ideally, treatment should begin as early as possible; though, fear of judgement and threat of lost custody impedes help-seeking, impacting wellness and recovery outcomes. This warrants an investigation into help-seeking behaviour to identify the ways in which stigma on micro and macro levels limits self-efficacy. For the purposes of this paper, help-seeking is defined as taking action to identify and access support for problematic substance use and related mental health concerns through traditional health care, treatment agencies, or peer support groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).

Moreover, conducting substance use research during a pandemic presents a unique opportunity to capture the impacts of a global health crisis on maternal mental health and recovery during times of heightened stress. At the population level, with insufficient resources for adequate economic, social, and medical response, public health emergencies contribute to increased emotional isolation, psychological distress, problematic substance use, and stigma (Pfefferbaum & North, 2020). Such stressors have been exacerbated for pregnant and parenting women who use drugs, as a population that already struggles with access to resources and care. For those with open child-welfare cases, due to social distancing obligations, mothers have experienced lengthy periods of separation from their children, posing threats to development of healthy attachment, particularly for infants (Jackson, 2020). There have been upticks of domestic violence upon the implementation of stay-at-home orders where victims have been isolated with their abusers (Kofman & Garfin, 2020; Thompson, 2021; Tolan, 2020), and children in families with greater mental health and financial risk factors may also be more vulnerable to abuse. (Brown et al., 2020; Lawson et al., 2020). Reports of symptoms of psychological distress and substance use have worsened for pregnant and parenting women over the course of the pandemic (Smith et al., 2021), and of additional concern, prenatal mental health problems increase likelihood of birth complications (Cardwell, 2013; Stein et al., 2014).

In sum, social inequity compounded by COVID-19 amplifies stress, restricts access to resources, and increases rates of problematic substance use. A lack of attention to these issues in government policy is representation of institutionalized stigma in of itself, and as such is a necessary consideration for this study. For these reasons, the impact of the pandemic on maternal mental health and recovery was examined in relation to stigma and help-seeking behaviour prior to the pandemic. Through understanding of experience, policy can be developed to break down barriers to care with a glimpse into support needs during times of global duress.

Self-Location

Reflexivity is an important part of knowledge production in which the researcher ought to critically examine their preconceived assumptions on a topic prior to making decisions about research design. Reflexivity involves self-location, in which there is a responsibility on behalf of the researcher to place themselves within the context of their work using a self-reflective process (Walshaw, 2008). Self-location is a valuable practice in the social sciences and health disciplines; consideration of the perhaps conscious and unconscious personal subjectivities that interfere with understandings and interpretation of a study throughout the data gathering and analysis processes enhances the quality of the study. More importantly, self-location acts as a way to resist oppressive, hegemonic principles and unsettle power by recognizing the ways in which privilege is constructed in society. To be conscious of subjectivities ultimately lends to the research process. As Indigenous scholar Hampton (as cited in Shawn Wilson's *Research is Ceremony*, 2008) states,

> One thing I say about research is that there is a motive. I believe the reason is emotional because we feel. We feel because we are hungry, cold, afraid, brave, loving, or hateful. We do what we do for reasons, emotional reasons. That is the engine that drives us. That is the gift of the Creator of life. Life feels… Feeling is connected to our intellect and we ignore, hide from, disguise, and suppress that feeling at our peril and at the peril of those around us. Emotionless, passionless, abstract, intellectual, academic research is a goddamn lie, it does not exist. It is a lie to ourselves, and a lie to other people. Humans feeling, living breathing, thinking humans – do research. We try to cut ourselves off at the neck and pretend an objectivity that does not exist in the human world, we become dangerous, to ourselves first, and then to people around us (p. 56).

Qualitative research is relational, and a researcher's ability to negotiate their positionality minimizes assumptions but also ensures critical thought enhancing both the validity of the findings and the ethical practice of doing research with whom there is a power imbalance.

Thus, prior to discussing my study, I first emphasize the importance of looking inward to interrogate the self. I identify as a white, middle-class, heterosexual, cis-gender female, identities which have granted me a great deal of privilege. I also acknowledge that I am a settler on stolen land in which the effects of colonialism remain prevalent to this day. I am someone with a diagnosed mental illness and a family history of addiction, thereby establishing my emotional connection to substance use research. With a background working with women in homeless and domestic violence shelters as well as involvement in projects focused on eliminating sexual violence against women on university campuses, I am deeply passionate about women's issues. My personal identities have undoubtedly set the basis of my ontological and epistemological roots from which my research stems, as I have adopted an interpretivist lens using a feminist perspective in an attempt to understand the subjective experiences of substance using pregnant and parenting women and their perceptions of the self, others, and society at large.

Chapter 2: Background

The Overdose Epidemic in Canada

Prior to the pandemic between January 2016-September 2019, Canada saw more than 14 700 apparent opioid related deaths and 19 490 opioid-related hospitalizations (Government of Canada, 2020) largely brought on by the rising presence of fentanyl and its analogues within illicit drug supplies (BC Coroner’s Service, 2019). Accidental overdose deaths have increased across the country since 2000, with the highest rates in British Columbia, Alberta, and Ontario (Statistics Canada, 2019). Emergency department (ED) data shows that in recent years, opioid-related ED visits have nearly doubled for women, with the greatest increase among those of childbearing years aged 15-44 (Belzak & Halverson, 2018). Indigenous women are disproportionately impacted; in BC, in 2020, First Nations women died at 9.9 times the rate of other BC women due to toxic drug overdoses (First Nations Health Authority, 2021). Public health emergency response efforts intend to draw attention to an issue and bring about swift action; though, oppositional response tactics from changing governments have prevented a targeted approach to ending opioid-related deaths on a Canada-wide level. Refusal on behalf of Health Canada to declare a national public health emergency despite mounting pressure from stakeholders has meant that resources allocated towards reducing substance use related deaths are limited (Duggan, 2018). While BC has declared a public health emergency related to overdoses, it is the only province in Canada to do so (Government of BC, 2022). The Yukon has followed suit after seeing a drastic rise in overdose related deaths in recent years (CBC News, 2022).

Impact of Substance Use on Families

All lives are touched by substance use in some way, whether directly or indirectly. For many families, patterns of substance use develop intergenerationally through a combination of environmental and biological factors that are established in early childhood. The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest investigations of the impacts of childhood trauma in relation to long-term health outcomes, assessing psychological, physical, and sexual abuse as well as domains of family relationships, household challenges such as witnessing abuse, substance use in the home, living in the home with someone with a mental illness, or having an incarcerated household member. Felitti et al. (1998) found that ACEs are common among the general population, with two thirds of study participants reporting at least 1, and more than 1 in 5 reporting at least 3. Additional findings show an increase in the number of ACEs leads to higher prevalence of problematic substance use, financial stress, depression, risk of intimate partner violence, suicide attempts, and unplanned pregnancy.

The connection between early life experiences and long-term health problems highlights the significance of addressing substance use in the family context. Due to the importance of safeguarding a stable household environment to ensure a child’s ability to thrive, family-oriented research regarding substance use and related problems has the ability to produce long-term benefits that prevent cycles of addiction and thwart the onset of stress-related diseases. Though, encumbered by environmental stressors, pregnant and parenting women face the greatest barriers to accessing mental health and substance use treatment (Poole & Isaac, 2001). Pregnancy is often a motivating factor in reducing substance use; yet fear of child welfare involvement and a lack of childcare and transportation all prevent enrollment in services (Milligan et al., 2011). While societal stigma experienced by people who use drugs is widely apparent, for pregnant and parenting women, judgement is heightened by the intersection of “mother” and “addict,” evident on both micro and macro levels (Sword et al., 2009). In addition to problematic interactions with service providers, disclosure of substance use in treatment settings may result in loss of child custody (Poole & Isaac, 2001). Child-centred discourse, in which the rights of the mother are pitted against the rights of the child, has dominated public health and social policy resulting in a combative rather than compassionate approach to recovery (Greaves et al., 2002). Moreover, research suggests that public health messaging regarding substance use during pregnancy may be misleading or inaccurate with harms over-exaggerated in the media (Boyd, 2004; Schempf, 2007). Such misinformation serves a political purpose to further ostracize substance using pregnant women from opportunities for treatment.

Stigma and Substance Use

Stigma has historical roots in classical Greece as a kind of tattoo that was branded on the skin of criminals, traitors, or slaves by way of cutting or burning to visibly mark them as outcasts or morally polluted persons (Gale Encyclopedia of Mental Disorders, 2003). Goffman (1963) co-opted the term stigma to describe the experiences of individuals who are rejected or socially discredited due to an attribute or behaviour that is deemed undesirable. In a similar vein, Cooley (1902) established the concept of the looking glass self to explain the process of socialization and the development of self-image. He purports that our sense of self forms in relation to others, and our interactions impact our thoughts and beliefs about who we are as individuals, steering behaviour.

Link and Phelan (2001) developed a contemporary conceptualization of stigma rooted in research of lived experiences. They outline 4 core converging components: (1) labeling of differences (2) labeled persons are deemed to possess undesirable characteristics through stereotyping (3) labeled persons are othered and (4) labeled persons undergo status loss and face discrimination. The authors posit that the production of stigma is contingent upon power structures that inherently allow for and reinforce the construction of differences which separate individuals into categories of “us” vs “them.”

Link and Phelan (2014) elaborate on the stigma-power concept, describing stigma as a means to an end for the stigmatizer. The system is advantageous for dominant groups by “keeping people down,” (through exploitation) “keeping people in” (boxed into societal norms and expectations) and “keeping people away” (ostracising those who possess abnormalities or deviate from said norms) (Link & Phelan, 2014, p. 25). In this way, the primary implication of these embedded status hierarchies is that the system itself reproduces inequities, regardless of the individuals in the system. In other words, Phelan et al. (2013) describe a feedback loop in which “macro-level inequalities are enacted in micro-level interactions, which in turn reinforce macro-level inequalities” (p. 18).

Several studies have documented the impacts of stigma on people who use drugs. A literature review by Yang et al. (2017) found that across the globe, common stereotypes of people who use drugs include dangerousness and unpredictability (Crisp, et al., 2008; Pescosolido et al. 1999; Corrigan, et al., 2009; Mannarini & Boffo 2015; Hengartner et al. 2013; Mushtaq et al., 2015; van Boekel et al., 2013; Sorsdahl et al., 2012; Sorsdahl & Stein 2010; Marie & Miles 2008; Herek et al., 2003), low decision-making ability (Pescosolido, Monahan & Lin 1999), blameworthy of their substance use (Crisp et al., 2008; Crisp et al. 2000; Mushtaq et al., 2015; Thege et al., 2015), and immorality (Mushtaq et al., 2015). Such beliefs carry weight when endorsed and enacted in spaces meant to provide support (Mak et al., 2017, Pauly et al., 2015; Yang et al., 2017). Stigma within health care settings has been shown to decrease engagement with treatment due internalization of stigmatizing beliefs (Mak et al., 2017), and fear of being mistreated following stigmatizing interactions (Pauly et al. 2015).

Stigma, Substance Use, and Mothering

Negative assumptions about people with problematic substance use are intensified by societal expectations for women as mothers (Sword et al., 2009). The female body has been traditionally depicted as a vessel intended to develop a healthy fetus, in which having and raising a child is a fundamental accomplishment of the female identity, according to patriarchal ideologies surrounding womanhood. The archetypal "good mother" is someone who fulfills her domestic duties as the primary caregiver, attends to the day-to-day needs of her child, and meets the needs of her child ahead of her own (Hays, 1996). This belief imposes expectations of unwavering devotion through 24/hour care without freedom to develop interests outside of the family (Ruddick, 2004). Dominant, Western ideology of motherhood holds women to rigid standards demanding selflessness, nurturance, and purity (Glenn, 1994) where fitness to parent is called into question with suspected substance use, especially for poor, racialized, and non-heteronormative women who deviate from socially constructed norms (Collins, 1991; Gupta, 1995). For this reason, Glenn, Chang, & Forcey (2016) describe the importance of recognizing mothering as a social rather than biological construct, highlighting the need for attention to the ways in which motherhood ideology serves to uphold status hierarchies within broader systems of oppression. Consideration must be given to historical gendered power relations, where women have been subject to social control within religious, economic, social, and medical institutions.

As Susan Boyd (2004) writes in *From Witches to Crack Moms*, rather than critically examine the systems that reinforce economic and structural violence against marginalized populations, poor and racialized women are villainized as social problems. The medicalization of pregnancy places women under a greater degree of scrutiny, control, and surveillance, whereby pregnant bodies are sites of risk (Burton-Jeangros, 2011). Risk management and monitoring are enacted by health care providers who may take punitive action to influence care compliance. In a qualitative study of post-partum opioid dependent women, Howard (2015) found that women perceive they are being devalued or dehumanized when interacting with health care providers on the basis of their substance use, leading to secrecy surrounding subsequent substance use. While generally intended to promote abstinence, stigma projected onto substance using pregnant and parenting women often only leads to disparagement which in turn individualizes issues of substance use without consideration of contextual factors. Such stigmatization has been shown to reduce rates of retention in healthcare and social services due to internalization of feelings of guilt and shame (Marcellus, 2004; Friedman et al., 2009; Davis & Yonkers, 2012). In addition to harmful interactions with service providers, disclosure of substance use in treatment settings often results in child welfare involvement, whereby removal of the child from the home is a legitimate concern (Poole & Isaac, 2001). A study led by the Centre for Gender and Sexual Health Equity at the University of British Columbia (UBC) found an association between increased rates of accidental overdose following the removal of a child from the home, particularly among Indigenous women (Thumath et al., 2021), indicating the degree of traumatization associated with forced separation. In many cases, treatment is perceived as coercive due to external pressure from child welfare over the threat of lost custody or as a condition for reunification (Davis & Yonkers, 2012). As such, stigmatization is a prominent barrier to accessing and receiving quality care (Wright & Walker, 2007; Stengel, 2014; Barrington, 2018).

Integrated Treatment Programs

To support families and address the complex lives of pregnant and parenting women who use drugs, comprehensive, integrated treatment models that give special attention to the social and medical needs of pregnant and parenting women have emerged with great success. These programs offer tailored care using a case-by-case approach, targeting base-level needs first in recognition of the fact that it is difficult to treat mental health when major stressors are present, such as a lack of stable housing or an adequate food supply. Evaluation studies have shown that these programs improve maternal mental health (Niccols et al., 2010), birth outcomes (Finnegan, 2013), child development (Pepler et al., 2002), and result in longer retention and engagement in treatment compared to non-integrated treatment programs (Milligan et al., 2011).

An important feature of these programs is the use of a harm reduction philosophy. Harm reduction is client-centred and refers to attempts to minimize the harms associated with substance use, where abstention is not necessarily an intended outcome or a direct indicator of success (Riley et al., 1999). Harm Reduction International outlines core principles to be applied in practice including: respecting the rights of people who use drugs, a commitment to evidence-based policy, a commitment to social justice and collaboration with community, and avoidance of stigma, with goals of keeping people alive and reducing harms of drug laws and policy. Harm reduction studies of clinical populations involving participants in substance use and mental health treatment settings emphasize the importance of the therapeutic relationship, in which understanding the client's goals and motivations in treatment helps to establish a sense of trust, facilitating a restorative bond (Denning, 2001; Tatarsky, 2003). Characteristic of treatment agency workers who align with harm reduction values, empathetic understanding and healthy channels of communication increase positive perceptions of treatment (Lee & Zerai, 2010), given that many individuals seeking support have experienced personal and institutional trauma (Little & Franskoviak, 2010).

In a thorough program description of integrated treatment programs across Ontario, Tarasoff et al. (2018) found that all integrated treatment programs operate under a harm reduction philosophy, with an emphasis on safer substance use and supporting client needs by “meeting clients where they’re at” (p. 12). Most programs use a trauma-informed approach to care, with others also incorporating client-centred, women-centered, strength-based, anti-oppressive, and/or feminist frameworks. All programs offer substance use treatment, including relapse prevention therapy, cognitive behavioural therapy, dialectical behaviour therapy, and motivational interviewing, though no programs provide opioid agonist therapy (OAT) directly. Counselling in these agencies is integral to treatment for mood, anxiety, and/or working through trauma. However, mental health support for children is less common, though many programs do offer prenatal care, parenting support, childcare, and life skills training in some capacity. An important service provided by all programs is coordination with child welfare services, including support attending meetings, facilitating supervised visits, navigating the court system, as well as emotional support.

Contextualizing the Research: COVID-19

In Canada as of May 2021, over 25 000 people have lost their life to COVID-19 (Government of Canada, 2021). Adverse mental health problems are known to emerge following traumatic social-historical events in which rates of post-traumatic stress disorder (PTSD), anxiety, and depression among the general public increase, both in response to the event itself as well as secondary consequences of displacement or unemployment (Norris et al., 2002). Research following 9/11 found that individuals who reported loss of a loved one in the attack were twice as likely to meet criteria for one or more mental disorders as the general public (Neria et al., 2008). In a longitudinal study exploring the relationship between post-traumatic stress symptoms (PTSS) among children following Hurricane Katrina, findings indicated that those with greater PTSS are less likely to seek out social support or perceive support as available (Lai et al., 2018). Similar outcomes, while not yet wholly known, have already been documented in the wake of COVID-19, which has generated a devastating societal burden alongside an already rampant public health crisis: the overdose epidemic. Experts predicted that COVID-19 would intensify the overdose epidemic due to heightened risk of overdose-related deaths as a result of social isolation and disrupted treatment and support services in the midst of an increasingly tainted drug supply (Belzak & Halverson, 2018). Reports began to surface in the early weeks of the pandemic in which emergency responders in some cities stopped using naloxone nasal spray (Blanchard, 2020; Little, 2020), an overdose-reversing medication that saves lives, due to fear of contracting the virus. With emerging pandemic research, it is apparent that experts were correct as feared; a report by the Ontario Drug Policy Research Network found that overdose-related deaths have surged, with a total of 2 050 people dying between March-December of 2020 compared to 1 162 deaths occurring in the same time-period in 2019 (Gomes et al., 2021). Moreover, at the population level, use of alcohol has risen due to greater levels of boredom and stress (Nanos, 2020), along with mental health issues (Panchel et al., 2020; Powell, 2020) and financial strain (Borrowell, 2020).

Important to note is the problematic nature of public health messaging such as “shelter in place” as this language fails to consider safety concerns for those living in unsafe households. Historically, women have been at greater risk of domestic violence during natural disasters and humanitarian crises with reduced protection and/or access to safe spaces (Aoláin 2011; Enarson, 1999; Fineman, 2010). Research regarding increased rates of domestic violence amid COVID-19 has already emerged, citing close contact with the victim and the perpetrator, heightened stress, lack of opportunities to escape, and greater isolation from outside contacts as reasons for increased incidents (Sacco et al., 2020). While the Government of Canada COVID-19 dashboard issued a factsheet on vulnerable populations including those with economic barriers, unstable housing, substance use, and difficulty accessing health advice (Government of Canada, 2020), support in the way of gender-specific concerns never surfaced.

In terms of COVID-19 itself, as noted by Afifi et al. (2020), inequitable social conditions surrounding money, power, and knowledge all contribute to higher prevalence of disease among marginalized populations. Insecure or congregated housing, lack of access to sanitation, and high-density workplaces not only increase susceptibility to disease but also result in greater severity. Moreover, access to support and quality care is reduced for people with disabilities (Armitage & Nellums, 2020), as well as racial and ethnic minorities due to medical mistrust and histories of maltreatment (Allan & Smylie, 2015; Alsan et al., 2020; & Pauly, 2014). For women seeking prenatal and postpartum care, research on the impact of COVID-19 and maternity services has found that limited interactions with health care providers has reduced perception of social support and contributed to greater pregnancy-related stress (Meaney et al., 2021; Sanders et al., 2021). In light of these factors, exploration is needed into the ways in which pregnant and parenting women with problematic substance use as an already marginalized demographic have been affected by COVID-19.

Gaps in the Literature

The effects of substance use-related stigma for pregnant and parenting women are particularly detrimental when considering the impact on not only mothers but their children as well. Integrated treatment programs emerged as a way to accommodate the needs of pregnant and parenting women who use drugs by tackling systemic barriers of financial constraints, transportation, and childcare needs through holistic treatment modalities that target a range of mental health issues in addition to meeting base-level needs. While there is data supporting the effectiveness of these programs, research regarding issues of access are lacking. What is needed is an in-depth look at the effects of stigma regarding substance use and mothering as it pertains to help-seeking, as well as an inquiry into how the pandemic has impacted maternal mental health and recovery. Through understanding of experience, policy can be developed to better serve the needs of this population in the Canadian context by learning what it means to create a hospitable environment for care.

Research Question

Ideally, treatment programs that target pregnant and parenting women should reach women within their first trimester of pregnancy to promote optimal health outcomes for both mother and fetus. Yet, there is a dearth of research examining treatment accessibility for this population. Improving access begins with creating a safe environment where women feel comfortable to reach out for help. Through a qualitative exploration of women who are currently receiving or have received support at various integrated treatment agencies for pregnant and parenting women who use drugs, I intend to understand how substance using pregnant and parenting women think, feel, relate to others, perceive the world, and take action in the context of stigma and help-seeking, both prior to and during the pandemic. This study seeks to answer 2 questions. The first is, how is stigma internalized, anticipated, and embodied in the context of help-seeking behaviour? Here, internalized refers to the absorption of negative attitudes that impact self-esteem; anticipated refers to an expectation of devaluation based on maternal substance use, ultimately reducing self-efficacy; and embodied refers to a holistic manner of being in which I propose that much like how trauma lives in the body (Van der Kolk, 2015), stigma also manifests physiologically. The second question is, what are the impacts of COVID-19 on maternal mental health and recovery? By engaging with a population in which the benefits of treatment can have a positive effect on future generations, findings contribute to a reconceptualization of recovery in the family context.

Chapter 3: Methodology

Research Design

This study employed the method of interpretive description (ID). Originating from nursing epistemology, ID deviates from traditional qualitative methods to provide an alternative approach for health researchers studying phenomenon classified as interdisciplinary (Thorne et al., 1996). Instead of focusing on theory generation, ID seeks to identify real world solutions to real world problems. Thorne (2016) describes the benefit of merging theory and practice, noting how the best patient care comes from balancing objective and subjective information in which clinical concerns must be examined within the framework of one's humanity. From a policy standpoint, ID can be used to identify ways to improve service delivery. The strength of ID lies in its flexible research design in that it does not require adherence to specific techniques within traditional social science methods such as grounded theory, phenomenology, and ethnography. Rather, formation of a coherent logic structure that fits to the phenomenon being studied allows for generation of practical findings with attention to disciplinary biases (Hunt, 2009). Given the multidisciplinary nature of substance use treatment which involves social service workers, health care providers, and peer support, ID is fitting for this study.

ID evaluates and borrows from traditional social science research methods to produce the best design necessary to achieve desired goals. Unlike phenomenology or grounded theory, this approach is situated within the literature so that the researcher can make connections to the work of others (Mitchell & Cody, 1993). A literature review provides much of the contextual background often lacking from research regarding barriers for pregnant and parenting women who use drugs, allowing for the formation of research questions that pair to conceptual understandings of stigma for this population. In the context of this study, what ID gleans from phenomenology is emphasis on participant accounts that capture the essence of experience (Husserl, 1970), where systematic procedures of the grounded theory tradition such as simultaneous data collection and analysis, qualitative coding, and memo-making are useful tools for interpreting the data (Glaser & Strauss, 1967).

For the reasons described above, ID was chosen for this study because of its flexible nature and ability to produce practical outcomes for interdisciplinary problems. By including a literature review, conducting interviews that generate understanding of experience, and using interpretive analysis strategies, micro and macro policy solutions can be derived to breakdown stigma as a barrier to care for pregnant and parenting women who use drugs. Given that its aims are of a more practical nature, ID does not always require a theoretical framework. For the purposes of this study, one was used to provide additional context and is drawn from feminist ethics, specifically relational autonomy, and is outlined in the following section.

Feminist Ethics

Gender roles are entrenched in Canadian culture through the process of socialization beginning before a child is even born. West & Zimmerman (1987) published the article, “Doing Gender,” to highlight the ways in which we display gender through behaviours and rituals. Everyday we encounter numerous miniscule decisions that require us to act within accordance of our gender, from choosing the clothes we wear to the bathroom we use. According to Goffman (1977), such daily decisions to conduct masculine or feminine identities “do not so much allow for the expression of natural differences as for the production of that difference itself” (p. 324). Today, there is perhaps no greater form of role expectation than that of women as mothers, begetting an unjust level of accountability on the part of women to be the primary caretaker, role model, and protector of her children, and as such women are subject to intense scrutiny upon any deviation of a decided set of norms and values.

In light of the above, it is imperative that research of this nature is informed by feminist ethics. In this way, principles of beneficence and autonomy must be reimagined to account for the contextual factors that influence actions, challenging an individualistic paradigm of decision-making. The notion of beneficence, which adheres to the belief that behaviour should benefit others (including preventing harm and injury), is a point of contention within the study of pregnant women, in which there is a dichotomy of woman-centred vs. fetus-centred care (Marcellus, 2004). Vangie Bergum examines the ideological shortfalls of separatism when considering medical practices of fetal monitoring:

> As we more frequently take a technological look at the woman and the foetus as separate entities it becomes credible for the foetus to become the patient and for the woman to be seen as the human incubator. From the point of view of women's experience of pregnancy such notions are totally foreign, in fact, repugnant. Pregnancy is not experienced as one versus the other (that is one plus one); rather, it is one with the other (two in one)-an altogether different relationship. The technological world of medicine does not understand this distinction. Technological fragmentation easily separates woman and foetus, biology and culture, public and private, mother and child and in doing so easily destroys, or at least disregards, the relational impulse (1997, p. 144).

A philosophy that considers the mother-baby dyad is needed, to more appropriately illustrate the unique emotional and physical relationship between mother and fetus. Shanner (1998) poignantly conceptualizes this connection as “pregnant embodiment” (p. 760). This philosophy captures the essence of the relationship between mother and child, highlighting an emerging need for treatment to focus on methods that holistically address maternal health. Separating what is best for mother compared to what is best for her child is insufficient in the context of family wellness.

It is with this belief that the core of this study is the theory of relational autonomy, a feminist approach which considers relationships as an integral, unwavering condition for self-determination (Sherwin, 2000). Feminist authors assert that life choices are inextricably connected to others, intertwined and embedded within power structures, cultural norms and values, and interpersonal relationships (Mackenzie & Stoljar, 2000). Relational autonomy thus contends that individuals with limited options, resources, or skills must not be scrutinized or branded as deviant for engaging in behaviour that does not conform to societal norms and expectations (McLeod & Sherwin, 2000). With compromised capabilities and opportunities at the hands of an unsupportive social environment, relational autonomy suggests that those who experience marginalization face the greatest barriers to exercising freedom of choice.

The concept of interconnectedness is not new. As argued by Overall (1989), adversarial perspectives do not serve either party. Rather, to protect a pregnant woman is to protect a fetus, where “genuine respect for foetal life would require genuine respect for women” (p. 42) through adequate support and fulfillment of basic needs. In this sense, policy and practice must reflect support for women and families.

There is an Indigenous worldview known as “all my relations,” a phrase often used at the beginning or end of a prayer to signify the kinship shared among human beings with each other, the land, animals, cosmology, and all other beings or things, living or inanimate (King, 1990). It is a reminder to understand one’s responsibility to themselves and the universe to live in harmony and with care for one another. Further cementing this idea are the Laws of

Relationships, a general summary of principles held by First Nations and Inuit cultures. Under the Laws of Mutual Support, people are strongest in groups, unable to survive on their own. The notion of a web of support is expressed in the Blackfoot term *aisspommootsiiyio`pa*, which translates to "helping one another" (King, 1990). In this way, all individuals rely on one another to have their needs met, beginning with the family and extending to the broader community.

Study Overview

Data for this study was collected as part of a follow-up to the Healthy Mothers, Healthy Families: Maternal Substance Use, Executive Functions, and Parenting Study. The Parenting Study is a longitudinal exploration of the impacts of substance use on executive functions (neurological mechanisms that support problem-solving and goal-setting) and parenting, led by Dr. Milligan in her Child Self-Regulation Lab at Ryerson University. It was initially approved by the Ryerson REB in 2017. Study sites for the Parenting Study include a number of integrated treatment programs for women, located in community-based substance use treatment facilities in Ontario (as free-standing community-based agencies, none has their own independent REB process). These services are covered by the provincial universal health insurance plan and accessed free of charge by Ontario residents. Of 36 integrated treatment agencies, 6 were purposively selected to capture a range of geographic locations, size, and years of operation. Data collection for the Parenting Study involved computerized tasks and surveys completed at multiple time points, with participants providing consent for re-contact in the future. In 2020, the Ryerson Research Ethics Board (REB) approved an amendment to cover additional data collection related to the impact of the COVID-19 pandemic on parenting outcomes, topics which emerged as a priority in the ongoing Parenting Study from both participants and study partners.

The present study was independently conceptualized to incorporate considerations regarding stigma as a barrier to care. As a sub-study, I developed the research design independently, though collaborated with the larger research team to adapt the line of inquiry to complement the Parenting Study, as I conducted interviews for both studies in tandem. Ethical approval was granted for the amendment to the Parenting Study by both Ryerson University and the University of Victoria REB in 2020.

Sample Size and Recruitment

Thorne (2016) suggests that anywhere between 5-30 participants is an appropriate sample size for research of this nature, though discretion should be taken when thinking about the nuance of a particular study. There should be consideration as to how to reasonably obtain the knowledge being sought, while balancing feasibility. She cautions against the use of the term *saturation* within applied disciplines, arguing that while individuals may fall into patterns, it is nearly impossible to fully grasp the range of diversity within social phenomena. Human experience is not universal or finite, and thus it is imperative to acknowledge endless variation among participant responses as well as potential for new information to emerge when discerning what constitutes a sufficient data set from one that is incomplete.

A research assistant at the Ryerson University Clinical Psychology Lab conducted recruitment using contact information from participants in the initial Parenting Study who had consented to re-contact for future research. Out of a sample of 19 former participants, 11 responded to the inquiry. 1 participant was not able to be reached after initial contact, meaning that 10 women were included in this study. Upon completion of these interviews, the research team discussed increasing the sample size to supplement data from participants involved in the initial Parenting Study, given that these women were predominantly out of treatment. An amendment was made to the REB and ethical approval was granted to conduct recruitment among the same integrated treatment agencies. A preliminary information letter (Appendix C) was sent out to integrated treatment staff to request assistance in this phase of recruitment by verbally informing participants, posting flyers and sending out the digital copy created by the Ryerson University research team (Appendix D). An additional 16 participants responded. 1 was excluded as they had already completed an interview from the first recruitment pool, and the final respondent was excluded as at this point, it was discerned that the complexity of accounts had been fully captured and no new data could be anticipated. Since a goal of this study was to describe a range of treatment experiences prior to COVID-19 as well as during, using a two-pronged recruitment strategy allowed for assessment of challenges experienced by women in different stages of recovery.

Data Collection

Telephone interviews were chosen as the preferred method of data collection. There are several notable advantages of telephone interviews including convenience as well as methodological strengths such as perceived anonymity, privacy, and ease of note-taking on part of the interviewer (Cachia & Millward, 2011; Lechuga, 2012; Sweet, 2002). Additionally, there may be a greater transfer of power to the interviewee in which they have more control over scheduling, interrupting, and ending the interview (Holt, 2010; Trier-Bieniek, 2012; Saura & Balsas, 2014). As noted by Drabble (2017), strengths for success include cultivating a rapport through informal exchanges, exhibiting responsiveness by demonstrating active listening, and communicating appreciation for the interviewee through acknowledgment of disclosure of personal information. Telephone interviews have the added benefit of safety during COVID-19, as no in-person interviews could take place during the duration of this study.

The first few interviews were conducted by a co-interviewer (a Ryerson University PhD student with prior interview experience), while I observed on the call for training. After each call, we had check-ins to discuss how the interview went as well as strategies for navigating the dialogue. Once the initial interviews were completed, we switched places and I led a call. At this point, we agreed I was equipped to carry out the interviews independently. Debrief meetings continued with the co-interviewer to discuss emerging themes and reflect on the line of questioning.

To ensure participants were in a safe and private space at the time of the interview, an environment check was conducted. This entailed asking the participant if it was still a good time to talk and if they were in a private location before beginning the interview. With the understanding that circumstances were such that children or other family members might be in the home, interview scheduling remained flexible, and participants were given the option to postpone if needed.

Broad, open-ended questions were asked to elicit responses involving feeling, experience, and opinion that capture matters of importance anchored in participant accounts (Patton, 2002). To combat bias, a reflective journal was kept throughout the process to maintain conscious thought of some of the often invisible, underlying assumptions that may influence research questions and subsequent interpretations while conducting interviews.

Informed by the knowledge that all individuals have strengths that deserve to be legitimized in the literature (Coghlan & Brydon-Miller, 2014), strengths-based questioning was used, which involves framing questions compassionately in ways that focus on overcoming barriers to treatment. The objective when using this approach was avoid perpetuating stereotypes by contributing to literature emphasizing qualities of resourcefulness, resilience, and agency, rather than focusing on deficits.

The interview guide (Appendix A) contained questions in categories of self-esteem, experiences accessing support, relationships with others, and mental health and treatment access during COVID-19. The intent with these questions was to gauge the extent to which stigma is perceived both internally and socially, and the relationship between such stigma and help-seeking both before and during the pandemic, as well as overall wellness in the midst of COVID-19. Questions were modeled after the Traumatic Antecedents Questionnaire (TAQ), designed to take life histories from individuals with traumatic pasts in an ethical manner to prevent re-traumatization (Herman, Kolk, & van der Kolk, 1990). In this way, interviews flowed from a series of practical questions regarding day-to-day life during COVID-19 to more revealing questions about relationships and social support. Regarding system navigation, participants were asked about pathways to entering treatment in the hopes of eliciting responses that reveal information about participants' interpersonal relationships and general feelings about various institutions without asking invasive questions. Van der Kolk (2015) notes that these types of questions help to ease tension when talking with a stranger, and create a comfortable environment where participants often volunteer detailed information about their experiences. Throughout the interviews, I took field notes that captured participants' tone of voice, hesitancy to answer questions, and any confusion surrounding the questions, which helped to guide future interviews. For instance, minor adjustments to question phrasing were made to better accommodate natural conversation flow, and ease into heavier content. After moving through experiences accessing supports and relationships with peers and loved ones, questions were rearranged to end the interview by asking: "As a mother, what do you need to feel supported in your recovery?" and "What do you wish people would understand about mothering and substance use?" Concluding the interview with these questions neatly encapsulated final thoughts, summarizing women's needs.

Demographic Data

To complement qualitative interviews conducted for the Parenting Study, a battery of quantitative questionnaires were administered by members of the Ryerson University research team through Qualtrics. Demographic information was ascertained alongside questions about substance use, mental health, home environment during COVID-19, parenting, stress, and relationships. Participants were given the opportunity to complete either the quantitative questionnaires, the qualitative interviews, or both. In total, 21 participants completed the questionnaires. I was granted permission to use the demographic information for my study, though of the 21 participants who completed the questionnaires, only 11 participated in both the questionnaires and the interview portion. Due to a lack of a complete data set, I have excluded demographic information from this study. Implications are discussed in the limitations section.

Data Analysis

Qualitative analysis has been described as an artform, or a type of detective work in which the investigator must hunt for themes that answer questions pertaining to an inquiry (Patton, 2002). Conducting research of this nature is a very immersive process requiring skillful handling of the data to make sound interpretations. Within an applied health research context, ID requires the researcher to understand and be familiarized with individual cases intimately in order to then make connections that can be applied to the life contexts of others facing similar realities. ID uses three key processes to achieve this goal through analysis: deliberate periods of immersion in the data dispersed with time in the field, constant comparative analysis, and iterative analysis (Thorne et al., 2004). Regarding the first process, Thorne et al. (1996) draw upon strategies from Knafl & Webster (1988) and Lincoln & Guba (1985) in which concurrent data collection and analysis allow the researcher to fully contextualize the data prior to establishing linkages through coding. Throughout the data analysis phase, Thorne (2016) emphasises the importance of knowing the data set well, beginning with transferring interviews from voice recordings to text. While I conducted the interviews myself, a transcriptionist was hired to record the data for efficiency. Transcripts were read several times in conjunction with field notes to deeply root myself in the emerging narrative. Second, constant comparative analysis involves simultaneous coding and analysis in order to make comparisons among data, themes, and theory (Glaser & Strauss, 1967). This involves a non-linear pathway in which the coding scheme is refined by being responsive to emerging data. Third, while ID does not seek to develop new theory, it still applies an inherently interpretive approach (Thorne, 2016), where reflexive iteration is achieved by asking important questions. Patton (2002) outlines 3 categories for triangulation regarding this process including questions for self-reflexivity (e.g., What do I know? How do I know what I know?), reflexivity regarding those being studied (e.g., How do the participants know what they know?) and reflexivity concerning the audience (e.g., How does the reader make sense of my work?) (p. 495). This method begins with initial points of interest leading to a refined focus.

Thorne (2016) encourages ID researchers to not be “derailed by excessive precision in your early coding” (p. 287). She compares sorting through data as a process similar to sorting laundry; the initial sort is broad and simple, such as separating darks from lights, moving to further categorizations accounting for differences of fabric and colour. Likewise, coding is an organizational process that begins with categorizing general emerging themes. Because ID is more concerned with recurring ideas rather than specifics within the language itself, patterns need not be scrutinized for extreme detail; it is the meaning that ID is most concerned with rather than the language itself (Thorne, 2016).

Using Dedoose software, I began with initial codes of Self-Perception, Impact of COVID-19, Relationships with Peers and Loved Ones, and Relationships with Health Care Providers and Social Service Workers. These initial themes were informed by the literature and preliminary read-throughs of the transcripts and were then sifted into categories of positive and negative experiences. Through memoing, a technique used to raise the quality of data abstraction by exploring feelings, ideas, and questions about the data (Birks, Chapman, & Francis, 2008), I took note of speech that connected to stigmatization like “shame,” “guilt,” and “feeling judged.” Such words were initially coded under the spectrum of “negative experiences” in the early read-throughs of transcripts as an umbrella for such emotive language so not to exclude any particulars in phrasing and accurately grasp shared intent among participant utterances. Additional themes emerged regarding barriers to treatment entry and support needs to mitigate stigma, and upon further abstraction, new categories were developed to parse out thematically linked accounts into specific, meaningful sub-themes.

Ethics

Informed Consent

Following the guidelines of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2) (2018), both written and verbal informed consent was obtained at the stage of recruitment, carried throughout the research process until the end of participants’ involvement in the study (Appendix B). Ample time and opportunity was given for participants to understand the information provided, ask questions, and fully consider their involvement. To ensure participants only revealed what they were comfortable with, care was taken to acknowledge and address important questions that might arise as a result of social vulnerabilities through empathetic understanding and by creating a safe, non-threatening environment. Special consideration was given to the sensitive nature of topics covered during the interview. Strategies used to minimize risk of harm included: providing an overview of questions ahead of time, letting the participants know that they only have to discuss what they feel comfortable discussing, pausing inquiry if the interview lands in difficult territory, and connecting the participant to resources following the interview, should they need counseling or support services. Such information was provided throughout the consent process.

Establishing Relationships with Persons

Jennings (2019) purports that in public health, solidarity (understood as a duty to promote and develop equitable outcomes) and care (characterized by affirming the needs and experiences of others) should be recognized as “practices” within health care and health policy. In this way, application of relationally theorized ethics involves a compassionate examination of both individual, case-by-case procedures as well as an investigation into problematic power structures in society. Health research, too, is highly personal and highly relational. Engaging in ethical research practices moves beyond obtaining informed consent and avoiding harm; there is a need for reciprocity in which the participant gains something from the experience. Research indicates that in depth, narrative-style interviews can be therapeutic (Madigan, 2011), though precautions must be taken to ensure that discussing sensitive topics do not result in the participant reliving trauma. This is done through communication with service providers to gain insight into best practices for working with this population. By using strengths-based questioning, less attention is focussed on deficits, meaning that interview questions instead highlight resilience to draw interest away from harmful stereotypes that lead to prejudice and discrimination.

Confidentiality and Data Privacy

Anonymity. All identifying information was deleted from transcripts and kept separate from participants' consent forms. Participants were given a unique study identification number for the purposes of analysis. The study identification number and contact information for participants was only accessible to members of the research team. Pseudonyms were used when depicting quotes in findings.

Limits to Confidentiality. Women were informed of the limits to confidentiality, including specific discussion of child welfare. This information appears in the informed consent form and was verbally reviewed with participants.

Use of Data. Audio recordings were used for transcription purposes. De-identified transcripts were analysed using Dedoose, a Canadian-based secure online qualitative analysis platform. Dr. Milligan holds a password-protected Dedoose account where transcripts were uploaded for analysis.

Storing Data. The interviews were recorded on a digital audio recorder, immediately transferred to the Ryerson secure server and deleted from the recorder. Electronic files were encrypted and password protected. Interview transcripts were identifiable through their unique identification number. Access to the study folder at Ryerson was restricted to the research team, and no files were stored on the hard drive of a computer. Any hard copies of the de-identified transcripts and consent forms were stored in a locked filing cabinet in Dr. Milligan's lab at Ryerson, and no study data was stored at the University of Victoria.

Interviews were transcribed by a research assistant at Ryerson and checked by a member of the study team for accuracy within 2 weeks of each interview, after which the audio recordings were deleted. All other electronic files are retained for seven years after the study completion. Hard copies of transcripts were destroyed upon analysis completion via a confidential shredder at Ryerson.

COVID-19 Considerations

Modifications were made to research design in compliance with guidelines to minimize the risk of disease spread. Recruitment was conducted over the phone and by email. Once interview dates and times were scheduled, each interview was done over the phone, averaging approximately 25 minutes in length per call.

Remuneration

There is some contention about the ethics of incentives in research, particularly when it comes to paying research participants with problematic substance use due to concern that money will be spent on drugs, potentially resulting in overdose (Festinger et al., 2005). Moreover, because substance use is often intertwined with poverty, one might argue that payment is a coercive practice to increase rates of participation (Fry et al., 2006). Though, concern over how one might spend research participation money contributes to a reductionist view of substance use and is an act of control beyond the scope of the researcher’s duty to gather data and interpret findings. For this study, payment for participants was made at the rate of $30 per interview in the form of an Interac e-transfer or Walmart giftcard, demonstrating value for time engaged in the research process in which the study would not be possible without the contributions of participants.

Rigour

When conducting research, it is important to ensure quality and integrity, respect confidentiality and anonymity of research participants, guarantee voluntary participation, avoid harm to participants, and demonstrate unbiased interpretation and analysis.

According to Lincoln and Guba (1985), the four indicators of trustworthiness pertaining to study quality are confirmability, transferability, credibility, and dependability. To achieve confirmability in which results are supported or corroborated by others, a detailed audit trail was kept. By maintaining a record during the research process about rationale for emerging codes and themes, the narrative is fully shaped by participants. Moreover, being reflexive is another way to circumvent bias on behalf of the researcher, by being aware of personal assumptions in order to set them aside.

While transferability refers to the degree in which research findings can be applied in other contexts, it is worth noting that because of the nature of substance use in which circumstances and effective treatment methods vary on a case-by-case basis, findings may not be relevant for all segments of the population. Though, often, the ways we relate to each other are through intimate details, and narratives have the power to establish connection through shared experiences. Studying in depth accounts of stigma within the health care system can be transferable to additional mental health studies outside of addiction, where stigma remains a prevalent issue in society impacting help-seeking behaviour.

Credibility was ensured through triangulation of data sources. In social research, triangulation involves examining data through different lenses to improve analysis (UNAIDS, 2010). By having two phases of recruitment involving women currently in treatment as well as women further along in their recovery, the study was strengthened in that accounts covered a range of experiences.

Dependability is important for trustworthiness because it means that findings are consistent and repeatable. Engaging in the above practices is helpful for dependability because it prevents misinterpretation of findings and ensures that researchers can capture truths in an objective manner, meaning the research can be successfully repeated.

Chapter 4: Findings

The following section details 4 major themes. First, in relation to stigma and help-seeking, sub-themes emerged pertaining to the impact of stigmatizing language, challenges associated with a partner preventing help-seeking, and negative experiences with health care providers. Second, participants discussed the impact of the pandemic on mental health, recovery, and service accessibility. Third, stigma on the structural level was examined pertaining to treatment initiation amidst issues of invisibility and the complexities of system navigation. Lastly, ways to mitigate stigma were identified through the presence of healthy relationships. Support from peers and loved ones, having a strong therapeutic bond, and desire for empathy and compassion were discussed. See table 1 for summary.

Theme	Sub-Theme	Summary
Stigma and Help-Seeking	Impact of Stigmatizing Language on Self-Perception	Derogatory language led to internalization of feelings of guilt and shame, negatively affecting self-esteem and lowering desire to seek help. Feeling judged resulted in concealment of substance use problems to preserve connection to loved ones. Women further along in recovery demonstrated greater ability to not internalize stigma compared with others.
	Partner Preventing Help-Seeking	Significant others inhibited help-seeking through control, isolation, shared addiction, and by restricting access to resources. Stigma associated with domestic violence was found to compound stigma associated with substance use, preventing help-seeking.
	Negative Experiences with Health Care Providers and Impacts	Negative encounters with health care providers occurred in two forms: through overt stigmatization of substance use as mothers, oftentimes leading to subsequent relapse, as well as through neglect in which participants described not meeting the threshold for treatment.
COVID-19 and Maternal Wellness	Mental Health, and Recovery	The pandemic exacerbated pre-existing mental health issues, where prolonged isolation in particular led to negative self-talk, jeopardizing sobriety.
	COVID-19 Impact on Access to Services	In instances where there was a desire to seek help, reduced service availability and prolonged wait-times put participants at risk of relapse. For many, virtual support came with a number of trials and tribulations, including distractions at home, privacy concerns, and the inability to make up for in-person connection. Others described benefits of virtual treatment including more flexibility and ability to attend meetings in other parts of the world.
Stigma at the Structural Level: Barriers to Care	Hidden Services	Participants described confusion surrounding initial steps as well as difficulty finding the right services and knowing who to reach out to.

	Treatment Initiation	Treatment was often initiated in one of two ways: (1) as part of crisis intervention or (2) through assistance from a friend or family member who had been through treatment before and could recommend services.
Mitigating Stigma to Enhance Help-Seeking: Facilitating Recovery through Relationships	The Role of Peers and Loved Ones	Family members, friends, and peers aided in the recovery process by providing practical support granting mothers time to attend treatment, as well as providing encouragement, boosting self-esteem.
	Therapeutic Relationships and Healing	Consistent, non-judgemental support was described as instrumental in recovery longevity.
	Compassionate Care	When asked about support needs, intangible qualities were most commonly described including “compassion” and “empathy.” Being treated with dignity greatly enhanced self-esteem and motivation for help-seeking. Participants described a desire for greater compassion within their interpersonal relationships as well as society at large, with recognition of the conditions that lead to substance use in order to create safer access to care. Negative feelings associated with being shamed for poor parenting as mothers with histories of problematic substance use negatively impacted recovery, and women contested the belief that substance use equates a lack of care for their children.

Table 1

Stigma & Help-Seeking

Impact of Stigmatizing Language on Self-Perception

Harmful language was discussed as damaging to wellbeing. Participants recalled incidents where derogatory words and phrases had been used to define them, feeling like their character was being reduced to their substance use history. Such instances were described as something necessary to overcome in order to improve self-esteem and get support. These interactions tended to weigh on the mind: “I definitely don’t process it too well. I definitely get really hurt” (Amy).

Internalization of attacks on substance use behaviour led to feelings of shame, which was noted as being less productive than compassion for encouraging recovery:

> Shame is just going to make everything worse for people trying to get support. We already feel that about ourselves, so we don’t need you to keep reminding us of the kind

> of person we are. We know we caused it. Don’t keep reminding us of the kind of person we are. Remind us how good we can be (Sandra).

For others further along in their recovery journey, there was a sense of resilience, in that women were able to tolerate stigmatizing experiences without it becoming internalized to where it impacted recovery or desire to seek help. Though, there was a sense of concern for women new to treatment, when reflecting on their early days in recovery:

> I’m not ashamed of who I am anymore. I used to be. But, you know, those people that are down and out and broken and you’re judging them or saying this and saying that, they’re not gonna come out and reach out, and they’re gonna hide, and they’re gonna feel alone (Gia).

> I really try to shrug it off, but it does bother me. It bothers me mainly because of how it can affect other people, like I feel like I’m pretty strong. I can usually handle things. But I think about the other person, like the person you talk to in recovery and has someone treat them like that. And then they relapse or, they go back to using because people aren’t going to appreciate them when they’re sober. That’s what really gets to me, like these people that are new in recovery and just trying to find their footing and then you have people degrading them for it (Janet).

As seen in the above accounts, women demonstrated a conscious awareness of the potential detriments of stigmatizing language. Both Gia and Janet acknowledged that judgement could impact recovery by causing people to feel alone in their struggles. Women tended to speak of stigma through concern for others rather than themselves, indicating that the degree to which stigma is internalized varies depending on environment and state of mind.

Participants who experienced judgement from peers and loved ones became disillusioned by the thought of seeking treatment. Rather than feeling comfortable disclosing treatment needs, attempts were made to shield loved ones from knowing about their substance use to preserve the relationship. One participant described how friendships became fractured in her past when disclosure of substance use issues led to judgement rather than understanding, resulting in a feeling of ostracization:

> I lost a lot of friendships and some family because of my addiction. When they were judging me instead of helping me and trying to understand, it made it harder for me to even get clean because I felt so guilty and shameful that I didn't want to come back to that and face them (Sharon).

Like Sharon, the desire to hide substance use was shared among Marianne who, "didn't want people to know… that [she] was using again." In this way, anticipation of stigma meant that participants felt a lack of safety in disclosure among interpersonal relationships.

Partner Preventing Help-Seeking

Significant others played an important role in recovery, at times to a detriment. Cassandra described "drinking a lot to try to cope with being in an abusive relationship." Despite willingness to seek support, for those whose substance use was tied to their partner's use, accessing treatment posed a threat to the relationship. In this way, the perceived emotional connection took precedent over maintaining sobriety:

> From my point of view, it was not all about being a bad mom or anything. It was being stuck in a relationship that I couldn't do anything, so that was my escape. Yeah, there's more to it for sure than what's on the surface. Yeah, it was being able to get out and

> finding somebody to let me know that I can be myself again…. My ex was controlling and wouldn't let me get help or even get away (Wendy).

> I had to get away from my son's father because we were in addiction together and I think that was, you know, if I had went right back to him obviously I would have fell right back into it (Amy).

For others, there was a noticeable difference in accessing recovery resources from being in an abusive relationship to now, having a bigger support system:

> This time around it was a lot easier, because my support group was kind of bigger, and I had a lot more people. Because when I was with my ex-husband, he kind of took all my friends away from me and kept me isolated (Jasmine).

As depicted by the women above, relationships can jeopardize sobriety through control, shared addiction, and isolation restricting access to supports, where abusive relationships exclude women from adequate resources for care. Such a dynamic inhibits taking action in which isolation creates a sense of secrecy surrounding the relationship itself as well as problematic substance use, preventing help-seeking.

Negative Experiences with Health Care Providers and Impacts

Correlation between stigmatizing experience and relapse.

Negative experiences with health care providers and/or social service workers were associated with subsequent substance use. Participants described having an encounter in which vulnerability was met with hostility, to the extent that they lost a sense of hope. One participant described the power of a conversation beginning with the initial point of contact for support stating, “Just being rude to somebody on the phone because they’re having a bad day could literally kill somebody, depending on what it is that they’re calling about” (Elizabeth).

Another participant illustrated a harrowing encounter with a health care provider, where stigmatization led her to relapse upon leaving a doctor’s appointment:

> I was pregnant and I went to my family doctor to get a referral for an OB, and he looked at me and told me to just go and find the adoption papers because I would never get better. I would always be a junkie. I would never get better. This man delivered me and has been my doctor since I was born…. I left and relapsed that day, and I was pregnant (Sandra).

What is highlighted in this account is an act of re-traumatization. In taking the step to seek a referral for medical care during pregnancy, Sandra was antagonized, where such an egregious encounter contributed to subsequent harm. Interactions such as these discouraged participants from seeking support in the future: “You feel like, what’s the point. Or you kind of feel like you’re set up to fail” (Cassandra).

Two participants described not feeling like a priority when at the hospital for mental health support, in which their care was neglected on the basis of their substance use:

> Yeah, so, the hospital thing – that bothered me…. They made me wait six hours for a psychiatrist, and I just laid in a dark room. And then they shoved me out when a girl – she came in with chest pain. So, they shoved me out into the hallway, and then they finally put me upstairs, and I was waiting for the psychiatrist, and I didn’t get to see them at all. They just sent me home, and guess what, I went home and snorted coke. Like, that’s not going to make me better. I needed to stay there (Elizabeth).

> There [were] times I went into the hospital and I didn't get proper care because I was an addict. They're like well, who cares, she didn't take care of herself why should we take care of her. And that's not okay because I went on to get better and you don't know what's going to happen to me. You don't know I'm not going to get better or I am. It's not a choice, like you're stuck in this place. I feel like they're supposed to give you care because you're at the hospital and my background shouldn't matter. It doesn't matter if I'm black or white or whatever so it shouldn't matter if I'm a drug addict or not. Yeah, I heard that a lot, like a lot, a lot, like discrimination because of using or being in recovery (Janet).

After taking the steps to seek support, for Elizabeth and Janet, stigmatization was experienced at point of intervention. More than subtle microaggressions, the care being sought was not offered, despite clear identification of needs for support. Like Cassandra, Elizabeth experienced relapse following her encounter at the hospital. For Janet, repeat experiences of discrimination because of substance use created mistrust of the system, where reaching out for support was no longer associated with getting help but rather being subject to hurtful rhetoric.

Not meeting the threshold for support.

Fear of invalidation of substance use or mental health problems was discussed as a common barrier to treatment. In instances where participants asked for support but were turned away, asking for help in the future became more daunting. For the following participant, rejection from services led to denial of personal needs:

> I feel like I shouldn't ask for help because that means that I can't do it, when in reality, yeah, I can't do it and I actually think that's okay in my head when I say it. But it doesn't

> feel right. I think maybe it’s our culture or our society, like we’re supposed to be able to (Alice).

Alice expressed the feeling that societal expectations of what one should and should not be able to manage were imposed on her. Internalization of stigma surrounding help-seeking meant that she had to wrestle with what she felt she needed vs. what she perceived to be an acceptable course of action by societal standards. Such feelings lend to what the following participant described:

> [I have a] fear of rejection. I’m so used to just hearing that I’m high functioning and things like that that I think that I’m just kind of like a little bit sketchy about asking for help and resources at times. It’s not like a pleasant feeling I guess when you try to reach out for help and someone says something like that. It just kind of closes me off when I’m trying to open up (Cassandra).

In this situation, attempting to access services led to dismissal of needs on the basis that Cassandra was not in imminent danger and therefore not worthy of help in overburdened system. Fear of neglect due to having a history of being told that her symptoms were not severe enough for intervention resulted in hesitation seeking help, where because she experienced rejection, she found it more difficult to express emotional problems moving forward. This notion contributed to a personal narrative common among participants of low self-worth.

COVID-19 and Maternal Wellness

Mental Health and Recovery

This section outlines the most common responses to issues impacting self-esteem and mental health during the pandemic. Body image, being stuck inside, heightened depression and anxiety, strained relationship with children, change in finances, and going through a break-up were all discussed as contributors to stress. Worsening mental health was often described as a product of isolation, where feelings of guilt and shame surrounding substance use became amplified, effecting self-esteem and jeopardizing sobriety:

> That was probably the hardest thing for me was being stuck in the house and being isolated. I couldn't just go see my friends. I couldn't just go see my family. I couldn't take my kids to a park and let them run around for an hour while I sat and had coffee with somebody and spoke to an adult. For me, those are big parts of my recovery. Isolation for me is a big trigger (Sandra).

As seen in Sandra's recount of the early days of the pandemic, losing simple daily pleasures that promoted wellbeing including visiting with friends and family impacted recovery in that it became more difficult to manage triggers. Having social interaction, which would usually be a healthy means of coping with stress, became a concern of safety in light of COVID-19.

Similarly, self-esteem was a prevalent issue throughout prolonged isolation in the pandemic, tied to personal feelings about past substance use, where negative self-talk became amplified:

> Because of my addiction, I lack self-esteem completely, but I just went to treatment in October/November, and I'm starting to feel better about myself. But it's up and down because being inside my home, gives me a lot of time to be inside my head, and then I'm living with a lot of guilt and shame and remorse (Sharon).

> I have a lot of insecurities and I think it causes me anxiety. And being alone in my head makes it worse, it builds, and I create stories of things that aren't happening because I'm stuck in my own head…. Before, I would go to more 12 step meetings, I would be in more regular contact with others, there would be distractions, there would be getting out which quiets my own mind a bit. And then also it allows me to talk to other people and you end up bouncing things off other people and you realize, like I find sometimes even just saying thoughts out loud you realize that they're not reasonable thoughts. But when they stay in your head, they just build. Being out would have changed a lot of that (Alice).

As described by Sharon and Alice, inability to combat low self-worth by turning to learned coping mechanisms as a result of the pandemic created greater susceptibility to internalization of stigma. Negative feelings associated with addiction were magnified, where being at home all the time detracted from participants' abilities to mitigate negative self-perception, and mental health issues were magnified. Lack of routine and the inability to derive support from typical resources caused additional stress that would otherwise be managed by seeing friends, getting outside the house, or reaching out to treatment agencies, counselling, or peer support.

COVID-19 Impact on Access to Services

Participants seeking treatment during COVID-19 faced additional barriers to access due to limited services and scheduling changes, when many businesses and organizations closed down. Travel restrictions, reduction in services, and wait times impacted recovery progress:

> But there wasn’t enough, you know, supports in place, and then with having to, with the pandemic being so bad right there I wasn’t even supposed to be traveling (Amy).

> Not as much is open. Like I know where the regular places are and stuff. But most places aren’t open, if you look stuff up online most of the numbers are for the actual place and then that place isn’t open (Janet).

For the following participant, despite having an established support system in place prior to COVID-19, due to worker changes, she had to continue her recovery with someone new who was unfamiliar with her case and needs. As a result, she expressed feeling like her recovery had hit a setback:

> I already had sources from before the pandemic started, or resources, sorry. I had my workers’ numbers. But when COVID hit, my addictions counsellor, she ended up going on leave or on break for a couple of weeks. There was a covering worker and I didn’t know her and she didn’t really know my story. I had to start over. I wanted my old worker back (Joan).

Prolonged wait times were another prominent concern in the midst of COVID-19:

> It was a struggle at first because the waiting list was so much longer, first off, and then you had to get a medical form, and it was hard to get into a doctor. It was a long wait to get your assessment done to go to treatment, and then once those things were done, you just have to sit and wait. Honestly, I waited, but I know that I’ve been in a position before that the wait time was too long, and I ended up going and using again, so sometimes that wait time could kill people (Sharon).

Reduced resources coupled with increased demand for mental health supports yielded potentially disastrous outcomes for some. More than just an inconvenience or added frustration, in some cases, increased wait times posed a threat to health and wellbeing.

While some agencies were able to make the transition from in-person to online support, participants described the challenges associated with virtual treatment, including greater distractions at home as well as a lack of in-person connection. Below, the following participants recount how a lack of connection was a noticeably missing piece from virtual treatment:

> I do find it's often hard, you're not getting the same out of meetings because you're not focusing as much. When you're at home there's distractions and on video you're going through things as opposed to really giving your undivided attention and hearing what's going on. Also, even in my 12-step programme we give hugs, which I thought was ridiculous when I started but there's something to be said for human contact, physical contact, even if it's just a hug or a pat on the back or something…. Seeing people in person created bonds, or allowed you to talk to others or hear others, whereas when you're meeting in meetings, you're not having one on one conversations and you're not able to connect. You're not meeting new people really, it's not the same form of connection (Alice).

> It sucks. I'm more of a hugging person and more face to face than through like a video or a call. It's so much better being in person (Wendy).

Without the comfort of being able to gather, hug each other, and build connection, participants felt like a major benefit of treatment was stripped away. What was described was a sense of authenticity that seeps through in-person contact that becomes obstructed when communicating through a screen. In some cases, participants confessed that it was easier to feign progress when meeting over the phone with a counsellor despite personal setbacks, on days when they felt reluctant to discuss their recovery progress (or lack-there-of).

Having other supports in place to bridge the gap once treatment supports diminished was beneficial for many, though there remained concern for women without a strong support system at home:

> So, for me to have to be forced to isolate, I can only imagine somebody who didn't have those supports in place and didn't have the people like I have. I was lucky enough that my fiancé was like, no, we're going to go drive. We're going to just drive for hours and hopefully we'll just see what we need to do. A lot of people don't have that (Sandra).

While participants overall preferred in-person treatment and counselling compared to virtual, some women acknowledged benefits of convenience, being able to attend meetings around the world, as well as less anxiety for those more introverted in nature by being able to observe without having to participate.

Many workers went above and beyond for their clients during the pandemic despite closure of many facilities. Despite lack of in person services, some participants explained that their worker would "come out and meet you to where you were" (Amy).

> Surprisingly and not surprisingly, I've been able to stay sober through all of it. I have a really, really good support system when it comes to my addiction, so I'm really lucky…. They're phenomenal. My counsellor made sure he texted me at least once a week through lockdown (Sandra).

Overall, participants who were able to maintain consistency with their routine, coping mechanisms, and relational supports fared better in the pandemic than those who did not have the same access. Those who had begun their recovery before the virus took hold had the advantage of developing an established support network over those who had just begun to seek support in the midst of the pandemic, though all women were impacted by service closures in some way.

Stigma at the Structural Level: Barriers to Care

Hidden Services

Challenges regarding system navigation were caused by limited knowledge of the resources available, where agencies and programs were hidden from mainstream public knowledge. Finding services only became more taxing when dealing with mental health challenges, as Cassandra noted: “I find that I don’t even really have the energy or the brain capacity to contact people.” Moreover, lack of continuity among services caused confusion, making access more difficult:

> I feel like programs are hidden…. It should be on ads and when you’re scrolling through Facebook, or… I don’t know. It needs to be everywhere, like posters, places, on TV there’s commercials, stuff like that. I don’t know. When I called, say, Treatment Agency-X, for instance, I was asking them what they can help me with. And they’re like, “Oh, you can schedule with your worker, and you know, they’ll chat with you.” And I’m like, “No. Tell me now – I want to know what group programs you run (Elizabeth).

> You know what, now that I’m a little more on top of everything, I’m finding it a little bit difficult, like I said, where I have all these… they sent off all the referrals, then I get a phone call, and it’s always a private number, and then I’m getting a little bit confused

> with all the different agencies, because I thought, ok, Treatment Agency-X is Canadian. And then, you know, my other worker will be like, "No, it's not that. That's in City-X." Then I think it's Treatment Agency-X, and it's just, yeah, and like I said, I'll have the certain ones call me and tell me I'm not eligible, so I've just finally now, a couple months in, like, somebody who I found myself to be pretty organized, I'm just starting to, ok, this is through these people and… yeah, I definitely think it's a little more [confusing] than I thought in the past (Amy).

These accounts indicate the invisibility surrounding substance use services within the community, making access to treatment difficult despite desire to seek help. Not knowing where to look for support was thus another barrier to treatment entry in addition to overcoming stigma and mistrust of the system.

Treatment Initiation

Event that precedes mandatory treatment.

Despite willingness for change, for several participants, the onset of treatment came only as a result of an event requiring mandatory intervention. Domestic violence or concerns involving child welfare facilitated introduction to an initial contact out of necessity who could then provide resources for ongoing support. Many participants described "guidance through CAS" (Children's Aid Society) (Wendy). This was often talked about in a positive light:

> When I was first starting my recovery, in a sense I guess I was lucky…because there was a lot of domestic violence. So, we had Family and Children's Services involved. For me, with having them involved, they put me right to the proper programs (Sandra).

> It was actually CAS that court-ordered it…It was good. I needed it, and I didn't realize I needed it (Jasmine).

> FACS facilitated a lot of my recovery stuff, like both times I was pregnant. And they were the main ones to tell me here is where you can contact, here is where you can go. I probably wouldn't have known what to do if it wasn't for them because the first time, I was very young and I probably wouldn't have had a clue otherwise (Janet).

Sandra, Jasmine, and Janet capture how CAS was able to intervene during opportune moments. Having a point person to connect to services was a necessary step for initiating treatment engagement, in which the information and support was welcomed. For these women, CAS was accommodating to treatment needs by providing a direct line of communication to various services. In doing so, women were able to bypass wait times and overcome difficulties navigating the system.

Personal link to treatment.

For the following participants, already having a sense of familiarity with substance use services from witnessing the experiences of loved ones eased the transition to treatment by having observed the process and receiving recommendations for programs from a trusted friend or family member:

> I was kind of comfortable with the whole situation, it's weird because I grew up in CAS, so I was kind of used to it for my mom because she went through addictions, too, or she had addictions. I was kind of used to the whole thing, and I knew what to do, what steps to take (Phoebe).

> I had a friend that went through Treatment Agency-X. She was going to go do this group, the mothers group, and she had asked Name-X if I could join because she thought that it would be beneficial for me (Cassandra).

Having connections to loved ones in recovery was essential for getting a foot in the door of treatment, helping to alleviate anxieties regarding first steps by having a referral and an understanding of the way the system works.

Mitigating Stigma to Enhance Help-Seeking: Facilitating Recovery Through Relationships

The Role of Peers and Loved Ones

46% of participants mentioned one or both parents as being their primary support system, followed by friends (13%), peers/agency workers at treatment centres (13%), then romantic partner (12%), extended family members (8%), siblings (4%) and children (4%). These relationships were said to add a sense of stability:

> Definitely my family is able to help out big-time with stability of my son, and I know that he was safe and in good hands. That was huge. That was a support for me, definitely, you could say, because he was being supported. It definitely gave me the time to do what I needed to do (Amy).

> I just need my family. And every other week doing my phone calls, my counsellor, and doing my rehab and completing it. And I’m going to graduate with honours. Yeah, as long as I have that and as long as I can pick up the phone and somebody’s going to be there to answer and to listen. And I do have that – I have two people that are counsellors that I can text anytime. And there’s people in NA, I have lots of phone numbers. As long as I have that (Elizabeth).

Having a close bond with family members was instrumental in that not only were they able to provide emotional support, but they could offer tangible support through childcare and other needs which granted women more freedom to devote time to their recovery, education, and overall wellbeing. Such opportunities were not as readily accessible for women lacking strong familial support.

Similarly, safe, healthy, romantic relationships were effective in boosting self-esteem. In addition to describing their partners as attentive to their needs, women described valuing the ways in which their partners remind them of their strengths:

> [My boyfriend] never makes me feel bad about myself or puts me down in any way, and I think that's the thing I need most in my life right now (Louise).

> I'm very lucky that I have someone in my life that is very good to me. And reminds me how hard I work all the time and how much I do, do instead of looking at all the things I don't do…. So even in those times I start feeling low, he kind of picks me up and dusts me off a little bit (Janet).

Having a partner sympathetic to recovery needs was recognized as helpful for staying on track. Where support needs extended beyond what could be achieved within the relationship, the following participant noted that her partner would encourage her to reach out to her treatment supports:

> [My boyfriend] knows about my addiction. He knows about my recovery. We met when I was newly in recovery, so he knows a lot of the triggers, which is really nice, so he can kind of see when I'm starting to veer off a little bit. It's okay, babe, go for a drive, I'll keep the kids, or just go get yourself a coffee. He's going to let me sleep in and he'll

> clean up the house. He makes sure that if I'm not in a good place and it's not something he can really help me with, he'll remind me to reach out to my supports (Sandra).

Outside of familial and romantic relationships, being able to talk with other women who shared common experiences was discussed by participants as an important aspect of recovery, due to establishing connection through relatability. Having a safe space to share experiences without fear of judgement was found to be empowering:

> I was getting, just, it was nice to get past experiences and struggles off my chest with other girls that went through the same thing, that was encouraging, that was uplifting as well. I always felt really good after I went to those meetings with them, and felt more on my feet, or stronger after I left there, so that's what initially drove me to do that and go (Louise).

One participant offered advice for those in recovery, highlighting the importance of maintaining recovery-based relationships:

> I've just been very grateful with the great group of ladies in my life through my journey. I'm grateful to have them in my life to this day. I would just say I would like to give some advice. Just keep them in your life, even when you think you're better. And even when you think that's behind you, you should always keep your support network. Keep in touch with them (Emma).

The following account highlights the importance of having the support of friends and family when in recovery, and the implications of perpetual experiences of judgment and discrimination:

> I was lonely. And I found lonely people. And I'd be like, "Hey, well, you wanna be my family?" And that would be who my family was until they had no use for me…. You keep judging people and pushing them away, they find those ugly, nasty people like I did…. I gave up my kids. Gave up my life. Gave up everything because I didn't have the support I needed (Gia).

Because of isolation brought on by the absence of a stable connection, Gia was vulnerable to developing unhealthy relationships that involved substance use. She further went on to express how her road to recovery was winding, and largely affected by those whom she was surrounded by during different periods in her life.

Therapeutic Relationship and Healing

While several participants had negative experiences accessing support when describing encounters with physicians, there were many accounts of positive experiences that were said to significantly contribute to sustained recovery with treatment agency staff. Workers at treatment facilities were described as dependable, and available for "whatever it is that you need" (Gia); "they become [like] family" (Emma).

Non-judgmental, compassionate care was an important quality expressed by women as being instrumental in having a positive treatment experience:

> This woman, she literally made me cry because she was so sweet. She was so sweet. I was like, "Oh my God, thank you so much that you have treated me so well." And she sat there with me for, like, half an hour as I wrote down all these different numbers I could call, and she explained a little bit about them (Elizabeth).

One participant described the benefits of having a counsellor who addressed areas of wellbeing outside of substance use, cultivating a holistic recovery lens:

> Most of the time, they're people that I don't like. It's hard to find a counsellor because it's hard to tell somebody how to deal with things or how to react and what to do if you've never been in their shoes. So, oh, go to the gym, go for a walk and get your mind off, stuff like that, that doesn't help myself or others who are there. Name-X, she doesn't judge, and it's not all focused on substance use. It's about other things too so she's helping me talk about stuff like that, but also, helping me grow in other areas of my life so she's amazing (Jorja).

Having a strong support system within the service sector was a significant element of recovery, in which consistent, compassionate care was demonstrated to be a strong buffer against stressors.

Compassionate Care

Compassion and empathy were described as the greatest support needs among participants, along with "a stable home" (Joan), "encouragement" (Wendy, Sandra), "unconditional love" (Helena), "trust" (Helena, Quinn, Amy), and "patience" (Louise). In a similar vein, women expressed the need for people in their corner, as "its so easy for somebody with [mental illness] and addiction to just veer off without that support" (Sandra).

> It's support and guidance, like that's what I would say. An active mother in substance abuse, they really just need love, empathy, and guidance in that situation (Emma).

Some women expressed the desire for understanding that recovery is possible, noting how stigmatizing labels can become weaponized and hinder one's ability to move forward, where any perceived fault becomes attributed to past addiction:

> For example, right now with the woman who has my son, she keeps holding that I was drug addict over my head. It's like once you're a drug addict you're always a drug addict. You're never going to be anything more or anything less. I worked really hard to get to where I am today, to get rid of that stigma of being a drug addict. It's just frustrating when people look at you like you can fall off the deep end any minute because they have no faith in your recovery, I guess (Naomi).

Participants described a desire for increased awareness about the conditions that lead to substance use and to be spoken to with dignity rather than judgement, stating a desire for "[not] so much stigma" and understanding that "it's possible to recover" (Alice). "Everybody has a past, and everybody has a story. They're not failures, they're just people that went through something and need help" (Avery).

Many women recognized that greater empathy comes with recognition of substance use as a mental health issue, where using is a coping mechanism to get through the hardships of life. As explained by Cassandra, for some, substance use is a survival tactic:

> The stigma itself, like especially towards mothers that have substance issues they just … I don't know. Society demonizes us and just thinks that we don't want to be mothers or we just don't want to exist. But I mean it's the complete opposite. To me it's more so about survival. It's almost like the better alternative versus what someone else's brain might go to instead of doing whatever their substance of choice is (Cassandra).

Lack of empathy regarding issues of substance use was often discussed in a tone of frustration and anger over the fact that society remains comfortable with blinders to the plight of people who are marginalized. In response to being called a "junkie," one participant described the internal dialogue that followed:

> Maybe if you actually understood addiction and understood that it's 9 times out of 10 linked to mental health issues, you might understand a bit more, not just, "Oh well, they're doing this because they need to get their next fix." Well, maybe you should sit down and understand it, you know? (Jasmine).

Experiences of hostility created friction for women and their loved ones. Participants expressed desire for curiosity, not judgement, and to be granted grace, not instilled with shame, for the betterment of their recovery.

The meaning of motherhood was discussed in the context of substance use, where women expressed desire for society to no longer instinctively equate substance use with unfit mothering, or a lack of love for their children:

> People are very quick to judge people who have children and who choose drugs over their children. I guess what I would like people to know is that it's not that I chose drugs over my children. It's that I chose their safety. That's how I looked at it anyway because I had a problem. And I couldn't get rid of it even though I had wanted to for my kids. It just wasn't happening at that time. I let my son go for his safety. So, I guess just maybe look at the bigger picture. If people are trying to recover for their children give them time, things don't happen overnight. People expect you to change and be there and adapt to everything right away and it's just not like that (Naomi).

> The stigma of [mothering and substance use] …one thing that I always remember hearing is, you know, like, “Oh, you don’t love them enough,” you know? Like, the drugs were more important and all that. And just really how that has nothing to do with it. Like, you can love so much, right, and could never even, you know, before I had relapsed, I never thought that I would be able to do that. But it’s how something really just completely takes over, you know (Amy).

Differential treatment among men and women accessing support for substance use as parents where men received praise and women received criticism was a noticeable phenomenon:

> It doesn’t make you a bad mom. There was something, when I was in treatment, it was like, the men, the fathers would all get praises for going to treatment, and the mothers, it would be like, oh. There’s always that double standard. Mom, you’re a bad person (Phoebe).

Overall, kindness exhibited through empathetic understanding, compassion, and non-judgemental support are important steps to eradicating the harms associated with stigma for this population. Experiences of such care generated positive outcomes, where having healthy relational supports was the bedrock for recovery. When asked about support needs, women expressed a yearning to feel seen wholly, not just for their substance use but as mothers and people deserving of care without fear that asking for help means risking mistreatment. As mothers in recovery, the desire to be rid of substance use related labels would mean freedom to have an identity that was chosen for themselves, rather than imposed upon them by systems and individuals in their lives who sought to perpetuate stigma through commitment to misunderstanding the complex relationship between trauma, mental health, and substance use, as well as the structural conditions impacting recovery.

Chapter 5: Discussion

Overview

This study used ID to highlight the impact of stigmatization experienced by pregnant and parenting women who use drugs, as well as the impact of COVID-19 on maternal mental health and recovery. 4 themes emerged. First, stigmatization played an important role in women's desire as well as ability to seek help and access support. Stigmatizing language and the use of derogatory words lowered self-esteem and inhibited safety surrounding disclosure. Participants further along in their recovery journey often spoke of concern for women early in recovery, indicating a greater ability to stave off internalization of stigma with adequate supports in place.

Among peers and loved ones, histories of negative reactions to substance use prevented participants from reaching out for both informal and formal support, due to fear of damaging the relationship. Isolation and stigma surrounding the relationship compounded stigma associated with substance use, preventing help-seeking. Many women spoke of past relationships in which their partner prevented help-seeking through control, isolation, connection through shared addiction, and restricting resources. Research on intimate partner violence (IPV) and stigma has shown that the perception of being blamed for the abuse as well as secrecy, shame, and social exclusion perpetuates internalization of negative beliefs about the self (Murray, et al., 2015). Like those with problematic substance use, for survivors of IPV, stigmatizing attitudes may come from professionals when seeking support in the form of blame and dismissal, further ostracising those in need from support and quality care (Crowe & Murray, 2015).

Past experiences with health care providers and social service workers greatly influenced recovery outcomes. Some women described associations between being stigmatized by a professional and subsequent substance use. In other cases, women faced mistreatment in the form of being turned away, with their concerns disregarded as non-urgent, and priority given to other, non-substance using patients. Such experiences had a negative impact on mental health, while reducing trust in institutions, and as a result, decreased motivation for help-seeking. While it was anticipated that participants in this study would share unfavourable attitudes regarding child welfare, client satisfaction with CAS was overall positive. The finding of non-compassionate care among health care providers may thus be a reflection of a lack of inter-agency collaboration in which integrated treatment programs strive to work directly with CAS workers to promote optimal outcomes, whereas clinicians remain on the periphery of these efforts. Positive perceptions of CAS in this study indicate there is perhaps a shift taking place within the institution, in which greater emphasis is placed on working together to achieve common goals for both mother and child. The holistic nature of integrated treatment programs as well as the involvement of a trusted service provider in facilitating interactions between mothers and CAS has been shown to improve outcomes and perceptions of care (Meixner et al., 2016; Tarasoff et al., 2018). It should be acknowledged, though, that the experiences of women in this study may not reflect the experiences of all. While integrated treatment programs are a step forward in repairing relationships among women with problematic substance use and CAS, there remains a long, oppressive history in which rates of child apprehension disproportionately impact Indigenous and Black families (Ontario Human Rights Commission, 2018). Reconciliation efforts remain as necessary as ever to dismantle colonial systems of power within child welfare.

Second, COVID-19 greatly affected mental health for participants striving to maintain their recovery, and despite greater need for supports, less were available due to safety concerns regarding illness transmission. Participants described the impact of the pandemic on their healing journey, in which self-esteem was lowered. For many, self-perception was tied to perceived judgement as a result of substance use. Negative self-talk was amplified in the midst of the pandemic, where many women experienced more time in isolation, with fewer resources available. With reduced access to support whether through formal treatment facilities or informal peer support, COVID-19 contributed to worsening mental health in light of the fact that women experienced heightened financial, emotional, and relational struggles.

Third, several structural barriers emerged, indicative of stigmatization on a macro level, compounding intrapersonal stressors. Hidden services and prolonged wait times discouraged treatment uptake. Women who were able to navigate the treatment system with ease described doing so as a result of having a personal connection to someone who had been through treatment already and could offer guidance. In other cases, treatment entry was the result of a particular event that led to police or child welfare involvement. While in this study such experiences were framed as a positive if not a necessary step for change, there is a lack of research that systematically examines women's experiences of treatment mandated by child welfare (Urbanoski, Merrigan, & Milligan, 2021). Digging deeper into the role of perceived coercion in treatment entry could serve to offer greater insight into women's recovery outcomes in comparison to those who enter treatment voluntarily. An exploration of this nature is pertinent given documented biases within the child welfare system (Trocmé, Fallon, Sinha, Van Wert, Kozlowski, & MacLaurin, 2013; Keddel & Hyslop, 2019;), in which as previously mentioned, the relationship between child welfare and women with problematic substance use has historically been found to be combative rather than supportive (Sun, 2000).

Women without external guidance struggled to navigate the complex system. Intervention came at point of critical need, not pre-emptively when the desire for support first emerged. Research has shown that entry barriers related to availability of services, service location, how services are provided, and organizational fragmentation, all systematically hinder access (Browne et al., 2016; National Treatment Strategy Working Group, 2008; Fischer et al., 2016; Urbanoski, Inglis, & Veldhuizen, 2017), and act as a deterrent to care (Priester et al., 2016). Compounded by stigma as a barrier to treatment entry, pregnant and parenting women with problematic substance use must overcome a plethora of roadblocks to access quality care.

In light of issues surrounding stigmatization upon disclosure as well as invisibility of resources and services, a number of support needs emerged to address such barriers to care and mitigate stigma, all of which were relational in nature. Women expressed a longing for societal understanding of substance use as a complex mental health issue, where stigma serves no purpose in promoting positive recovery outcomes, instead only exacerbating emotional stressors. The notion that problematic substance means a mother does not love her child was vehemently contested.

Overall, women emphasized the value of healthy relationships, where with the right support, they were able to achieve longevity in their recovery. Several women spoke of the bonds created with their treatment agency workers, who were described as going above and beyond to accommodate client needs. As noted in previous research (Desrosiers, Thompson, Divney, Magriples, & Kershaw, 2016; Jones, Tuten, & O'Grady, 2011), relationships with peers and loved ones had either an intensifying effect or a buffering effect on substance use. In this study, having a supportive partner was described as being a critical factor in maintaining sobriety and wellbeing overall, where relationships involving domestic abuse prolonged help-seeking.

Going Deeper: Internalization, Anticipation, and Embodiment of Stigma

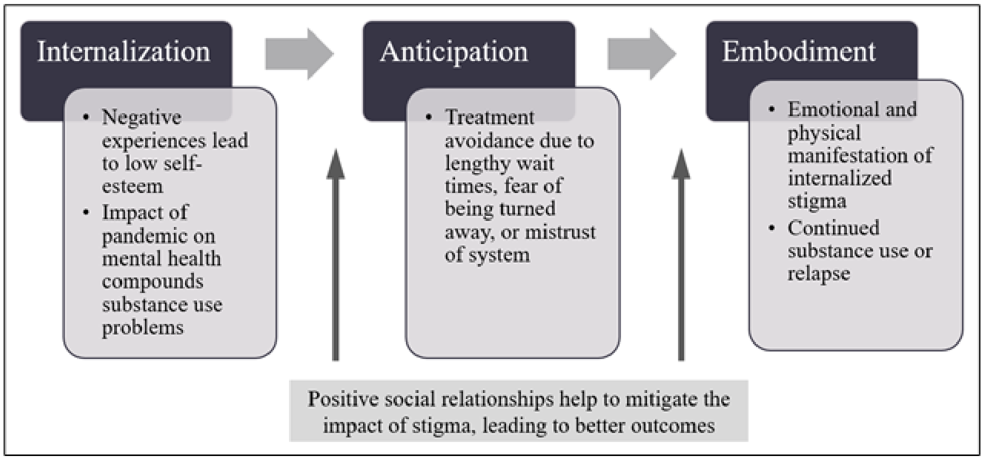

Figure 1

Figure 1 highlights how the mechanisms by which stigmatization leads to negative outcomes can be traced along a pathway stemming from one or more past interactions or events. Being judged, ignored, or treated poorly sparks a trajectory in which an individual may experience negative emotions that lower self-worth (internalization), followed by avoidance of treatment due to lengthy wait times, fear of being turned away, or general mistrust of the system (anticipation), leading to risk of heightened emotional and/or physiological problems in addition to continued substance use or relapse (embodiment). In an already highly traumatized population, stigmatizing experiences can lead to re-traumatization, triggering over-activation of the body’s stress responses, and as a result, perpetuate maladaptive coping mechanisms (Maté, 2008; Haskell, 2013). In this way, stigma is a risk factor for negative health outcomes.

Structural violence plays out through discriminatory practices as well as by creating invisibility surrounding issues of substance use. Similar findings have been discerned in research of HIV patients; a systematic review by Reuda et al. (2016) found that HIV-related stigma was associated with higher rates of mental illness, worsened physical health, lower levels of social support and decreased adherence to medication. Moreover, reduced usage of health and social services was a strategy used to conceal HIV status and avoid discrimination. In the present study, healthy, supportive relationships acted as a buffer against stigma and subsequent internalization, leading to better health outcomes. If addiction were like wading through ocean waves, the undertow would be trauma, poverty, and limited access to resources, and social support would act as a life raft.

Implications for Policy and Practice

Mental Health and Substance Use Literacy

As cited in Corrigan et al. (2015), educational programming in which governmental and non-governmental organizations have rolled out campaigns focused on encouraging people to seek support and erode mental health-related stigma has yielded positive results (Hickie, 2001; Dunt et al., 2011). Australia's Beyond Blue mental health organization was associated with greater awareness of mental health first aid (Yap, Reavley, & Jorm, 2012) as well a deeper understanding of the benefits of treatment (Jorm et al., 2005). Implementation of such campaigns surrounding substance use targeted towards populations with greater vulnerability to stigma (such as women of child-bearing age) could serve to disseminate knowledge surrounding the complexities of substance use and trauma, where compassion about such issues is more commonplace.

Education on pathways to addiction is necessary in social work and health care fields, particularly with attention to cultural context. Jeannine Carriere (2018) cites Blackstock (2011, p. 188) who writes of ideologies that led to the Sixties Scoop in which child welfare services in the '50s were often carried out by social workers who "had little to no knowledge about colonization and residential schools [and] often mistook symptoms of systemic discrimination as parental failure." Such fallacies have remained intact to this day. Curriculum for social work and medical programs must go beyond a historical recollection of trauma to present day reflections of the ways in which the effects of colonization are ongoing, and the role of whiteness in continued structural violence.

Cultural Safety, Harm Reduction, and Accountability

In a similar vein, overarching practices are needed in healthcare and social service fields which mandate compassionate care to ensure safety among women and their families, so not to perpetuate harmful stereotypes. Consistent with other research (Peckover & Chidlaw, 2007; Henderson et al., 2008; Harvey et al., 2015; Howard, 2015) women in this study reported experiences of stigmatization within healthcare settings on the basis of substance use. Inability on behalf of service providers to foster a healthy relationship presents a missed opportunity to connect women with services and encourage treatment uptake. As such, hiring practices should reflect standards of empathy, compassion, and cultural safety with employees having a demonstrated understanding of the needs of people who use drugs.

To expand on the importance of organizational values, research indicates the ways in which harm reduction implemented across settings can enhance patient-centred care and improve outcomes. McNeil et al (2016) found that hospital-based harm reduction that prioritizes risk reduction, acknowledges pain and withdrawal, is attentive to health needs and decisions, and promotes cultural safety can help to rebuild patient-provider trust through de-stigmatization of substance use. Further, prioritization of safety using a trauma-informed approach can be particularly beneficial for this population, with evidence that problematic substance use among women is rooted in trauma (Marcellus, 2014). Such implementation could create accountability where practitioners who do not adhere to standards of care face repercussions. Cross-sector collaboration would greatly aid in this process. Marcellus et al. (2015) found that expanding conceptualizations of success beyond a finite measure of abstinence to capture safety and respect as well as the use of a multidisciplinary team can enhance perceptions of care.

Lessons for Health Care Providers

Beyond upholding principles of harm reduction, this study yielded findings that glean insight into practical tools to be employed by health care providers when working with pregnant and parenting women who use drugs. In particular, women expressed desire to be treated for their wellness and medical needs without receiving differential treatment on the basis of their substance use. Using person-first language, which by definition involves identifying people as individuals worthy of care rather than attributing secondary or incidental qualities or conditions as primary characteristics (Canadian Centre on Substance Use and Addiction, 2020) helps to de-stigmatize substance use, eliminate bias, and improve quality of care. Literature indicates that using best practices for cultivating a strong therapeutic relationship including committing to compassionate care and using non-judgemental language encourages treatment engagement, leading to better outcomes (Alexander, 2017; Marcellus, 2014).

Investment in Social Safety Nets

Campbell (2000) describes a persistent discourse in which transfer of responsibility of social problems onto figures that embody them remains a policy failure which only causes further harm to vulnerable communities. Regarding this viewpoint, she writes of the patriarchal perception in which, “women who lack maternal instincts produce the structural effects of economic erosion and neighborhood disintegration,” (p. 182) a narrative which demonizes “deviant” mothers, providing the basis for punishment rather than treatment, as well as justification for cutting social funding for mental health services or substance use treatment on a structural level. While this is a widely accepted ideology for many, expansion of social safety nets can in due course have tremendous long-term social and economic benefits (Ball, 2009; Nurse et al., 2013; Suhrcke, 2008). According to a 2016 Public Health Agency of Canada (PHAC) publication, 50% of Canadian healthcare dollars are allocated towards the 20% of Canadians with the lowest income (p. 50). On a local level, an impactful study which illuminated the relationship between social conditions and health in Hamilton, ON, found a 21-year difference in life expectancy among the city's poorest and most affluent neighbourhoods, with stark disparities also reported among rates of secondary school drop-outs, ER visits, low birth weight babies, and teen pregnancy (Buist, 2010). In society, we fund what we value. Substance use, as a symptom of poverty and trauma, can thus be addressed in the context of additional public health goals that target a spectrum of social inequities. Basic income, affordable housing, universal childcare, and support for parents to enrich home environments are some of the ways to reduce health disparities and eliminate vulnerabilities to problematic substance use through means of preventative action.

Support During a Pandemic

Findings pertaining to COVID-19 indicate that mental health was impacted by limited supports and lengthy wait times. While some agencies were able to quickly adapt and offer virtual services, others were not. Moreover, due to distractions, issues of privacy, and lack of connection, participants expressed preference for in-person treatment over virtual. According to the CCSA (2020), the pandemic unveiled longstanding issues regarding availability of healthcare and social services, where reduced access to treatment and harm reduction services amplified risk of overdose. For those in precarious circumstances, strengthening supports rather than eliminating them during periods of social and economic crises could save lives.

Empathy: A Cultural Shift

All of the above policy changes require a cultural shift in the way we think about substance use in order for change to be embraced and implemented by policy makers. In *All About Love*, bell hooks writes, “Rarely, if ever, are any of us healed in isolation. Healing is an act of communion” (p. 215). As social beings, the desire to connect and seek safety in companionship is not a weakness but rather a sign of healthy instinctive capacities for growth and adaptation (Gibson, 2015). How, then, in an individualistic society which claims the fallacy of a meritocracy, heavily emphasizing personal responsibility for life choices without critical interrogation of oppressive systems, can we cultivate empathy? bell hooks articulates how developing empathy requires a level of internalization and self-reflection derived from sitting with the discomfort of negative emotions to develop a sense of compassion for others. In a capitalist society, those most privileged are not incentivised to take part in this process (despite having the resources) but instead seek to maintain power. We are not inherently taught to critically examine our privilege, but rather to preserve it. To embrace the idea of relational autonomy, then, requires a radical transformation of how we are socialized to move away from an individualized understanding of the way the world works to instead challenge our own privilege and reflect upon our place in this world in relation to others and our environment.

In her book, *Immunity: An Inoculation*, Eula Biss describes society as a garden which we must all tend. She writes:

> If we extend the metaphor of the garden to our social body, we might imagine ourselves as a garden within a garden. The outer garden is no Eden, and no rose garden either. It is as strange and various as the inner garden of our bodies, where we host fungi and viruses and bacteria of both 'good' and 'bad' dispositions. This garden is unbounded and unkempt, bearing both fruit and thorns. Perhaps we should call it a wilderness. Or perhaps community is sufficient. However we choose to think of the social body, we are each other's environment (p. 173).

While she uses this framework to consider the importance of vaccines in achieving herd immunity, the social garden metaphor can be extended to the concept of addiction. In an equitable society, all individuals benefit. In an unequitable society, all individuals bear the burden. Capitalism is a system that demands selfishness for individual success, and does not so much favour the prioritization of needs that are outside of our own periphery. Grassroots efforts begin within the home, where all individuals, particularly those of privilege, reflect upon and evaluate their relationships. To come full circle, compassion is an exercise which must be practiced first with ourselves, and then with our families, friends, and the world at large.

Limitations

Limitations of this study include the lack of demographic data, issues of generalizability, the potential for social desirability bias, and the absence of member checking. Regarding the former, detailed demographic data could have strengthened this research by providing richer insight into the study population. While some participants disclosed their race/ethnicity, age, gender identity, and/or sexuality, having descriptive characteristics would have allowed for greater nuance into the population and enhance understanding of needs for women accessing support. Second, Ontario is a large province with vastly different geographic and social conditions. Conducting this study in partnership with a handful of treatment agencies might mean that the findings are not transferable to those in other provinces who may have unique stigma experiences depending on the setting. Regarding social desirability bias, because findings are based on interview data, there is potential for participants to attempt to answer questions in a way that will be viewed favourably by the researcher. Given the content of the study, there may be hesitation to talk about substance use during pregnancy, especially without prior connection in which rapport can be established. Lastly, due to time and funding constraints, member checking was not feasible meaning there is a greater possibility for misinterpretation of participant accounts.

Directions for Future Research

Exploration is needed to understand the ways in which intersecting identities such as race, class, sexuality, and mental health status are built into societal expectations of the ideal mother, and how these expectations are embedded within power structures, affecting access to care. While this study provided insight into help-seeking for women who had been able to successfully overcome barriers to access services, to improve quality of research in this area, future studies should seek to investigate the experiences of women who have never reached this point of intervention, with special attention to race and ethnicity. In two large scale evaluations including Healthy Mothers, Healthy Families (Urbanoski et al., 2018) and Breaking the Cycle (Pepler et al., 2002), demographic data collected showed that those served in treatment are predominantly white women late in their pregnancy or women who are already mothers. Little research has addressed stigma from the perspective of how experiences vary among women of differing backgrounds, where judgement associated with mothering and substance use may be further exacerbated for women with racialized or non-heteronormative identities. Canadian literature indicates that there are disproportionate rates of racialized children in the child welfare system beginning at point of assessment through to continued decision making (Mohamud et al., 2015), where punitive action is favoured in cases involving Black and Indigenous families at higher rates than white families (Antwi-Boasiako, 2020; Children's Aid Society of Toronto, 2015; King et al., 2017). Indigenous children account for 7.7% of the child population, yet make up 52.2% of children in child welfare (Government of Canada, 2016). Even more stark in the prairies, according to the latest Manitoba Families' Annual Report (2020), 90% of children in foster care are Indigenous (p. 73). Inextricably linked to poverty, the foster care to youth homelessness pipeline is clear; according to a national youth homelessness survey, 57.8% of homeless youth aged 13-24 had some involvement with child welfare (p. 9), with even higher rates of homelessness experienced by transgender and non-binary as well as LGBTQ2S youth.

As with this study, research has shown that prior experiences of discrimination can lead to mistrust of the health care system (Armstrong et al., 2013; Brenick, 2017; Gamble, 1993) resulting in lower service utilization (Browne et al., 2011; Cameron et al., 2014; Denison et al., 2014). Knowledge of these disparities lends to an understanding of the dangers for non-white, cis, heterosexual women accessing support, where threats to mental, physical and familial relationships are evident. In light of these issues, attention must be given to the concept of intersectionality and the ways in which women experience stigma differently depending on their personal life histories, and explore how racial disparities among women in treatment and the child welfare system lead to delayed treatment seeking.

Conclusion

Pregnant and parenting women with problematic substance use are an optimal group to receive treatment intervention, where motivation to seek help is often at a high point and the benefits of recovery can have positive generational impacts. While there are many treatment agencies that provide instrumental support, stigma surrounding substance use and mothering remains pervasive in our society, preventing help-seeking due to a lack of safety for women to express the need for help where judgement lowers self-esteem and disclosure threatens to damage interpersonal relationships. On a structural level, hidden services and lack of compassion within the medical community further acts as deterrent for reaching out for support, due to past experiences of harm resulting in mistrust of the system. In the midst of COVID-19, where support needs increased as a result of prolonged isolation and abrupt changes in environment and circumstances, reduction in services only amplified recovery challenges. In order to increase help-seeking behaviour and improve outcomes for this population, creating a culture of compassion is critical. Supportive relationships among friends, family, peer groups, and treatment agency workers and health care professionals can act as a strong buffer against stigma-related harms.

References

Afifi, R. A., Novak, N., Gilbert, P. A., Pauly, B., Abdulrahim, S., Rashid, S. F., ... & Ferrand, R. A. (2020). ‘Most at risk’ for COVID19? The imperative to expand the definition from biological to social factors for equity. *Preventive Medicine*, *139*, 106229.

Alexander, K. (2017). A call for compassionate care. *Journal of Addictions Nursing*, *28*(4), 220-223.

Allan, B., & Smylie, J. (2015). *First peoples, second class treatment: the role of racism in the health and well-being of indigenous peoples in Canada, discussion paper.* Wellesley Institute.

Alsan, M., Wanamaker, M., & Hardeman, R. R. (2020). The Tuskegee study of untreated syphilis: A case study in peripheral trauma with implications for health professionals. *Journal of General Internal Medicine*, *35*(1), 322-325.

Antwi-Boasiako, K., King, B., Fallon, B., Trocm´e, N., Fluke, J., Chabot, M., & Esposito, T. (2020). Differences and disparities over time: Black and White families investigated by Ontario’s child welfare system. *Child Abuse & Neglect*, 107, Article 104618.

Aoláin, F. N. (2011). Women, vulnerability, and humanitarian emergencies. Mich. J. Gender & L., 18, 1.

Armitage, R., & Nellums, L. B. (2020). The COVID-19 response must be disability inclusive. *The Lancet Public Health*, *5*(5), e257.

Armstrong, K., Putt, M., Halbert, C. H., Grande, D., Schwartz, J. S., Liao, K., ... & Shea, J. A. (2013). Prior experiences of racial discrimination and racial differences in health care system distrust. *Medical care*, *51*(2), 144.

Badgett, M. V., Choi, S. K., & Wilson, B. D. (2019). LGBT poverty in the United States: A study of differences between sexual orientation and gender identity groups.

Ball, J., DesMeules, M., Kwan, A., Jacobsen, L., Luo, W., & Jackson, B. (2009). Investing in prevention: The economic perspective. Key findings from a survey of the recent evidence. *Public Health Agency of Canada*.

BC Coroners Service. (2019). *Fentanyl-detected illicit drug toxicity deaths January 1, 2012-October 31, 2019*.

Belzak, L & Halverson, J. (2018). Evidence synthesis-The opioid crisis in Canada: a national perspective. *Health Promotion and Chronic Disease Prevention in Canada: Research, Policy and Practice*, *38*(6), 224.

Bergum, V. (1997). *A child on her mind: The experience of becoming a mother*. Praeger.

Biss, E. (2015). *On immunity: An inoculation*. Place of publication not identified: Fitzcarraldo Editions.

Birks, M., Chapman, Y., & Francis, K. (2008). Memoing in qualitative research: probing data and processes. *Journal of Research in Nursing*, 13(1), 68 – 75.

Blanchard, S. (2020). An Indiana police dept. no longer reversing overdoses during pandemic. *Filter Mag*. Retrieved from: https://filtermag.org/cops-naloxone-coronavirus/.

Bonevski, B., Randell, M., Paul, C., Chapman, K., Twyman, L., Bryant, J., & Hughes, C. (2014). Reaching the hard-to-reach: a systematic review of strategies for improving health and medical research with socially disadvantaged groups. *BMC Medical Research Methodology*, 14(1), 42.

Borrowell. (2020). *Survey reveals 3 in 4 Canadians experiencing financial stress due to COVID-19.* Retrieved from: https://borrowell.com/blog/survey-reveals-3-in-4-canadians-experiencing-financial-stress-due-to-covid-19/.

Boyd, S. C. (2004). From witches to crack moms: Women, drug law, and policy.

Brenick, A., Romano, K., Kegler, C., & Eaton, L. A. (2017). Understanding the influence of stigma and medical mistrust on engagement in routine healthcare among black women who have sex with women. *LGBT health*, *4*(1), 4-10.

Brown, S. M., Doom, J. R., Lechuga-Peña, S., Watamura, S. E., & Koppels, T. (2020). Stress and parenting during the global COVID-19 pandemic. *Child Abuse & Neglect*, *110*, 104699.

Browne, A. J., Smye, V. L., Rodney, P., Tang, S. Y., Mussell, B., & O'Neil, J. (2011). Access to primary care from the perspective of Aboriginal patients at an urban emergency department. *Qualitative Health Research*, 21(3), 333–348.

Browne, T., Priester, M. A., Clone, S., Iachini, A., DeHart, D., & Hock, R. (2016). Barriers and facilitators to substance use treatment in the rural south: A qualitative study. *The Journal of Rural Health*, *32*(1), 92-101.

Burton-Jeangros, C. (2011). Surveillance of risks in everyday life: The agency of pregnant women and its limitations. *Social Theory & Health*, *9*(4), 419-436.

Buist, Steve. (2010). Code Red: Where You Live Affects Your Health (Special Report). *The Hamilton Spectator*. Available from: http://thespec-codered.com/?page_id=8.

Cafferky, B. M., Mendez, M., Anderson, J. R., & Stith, S. M. (2018). Substance use and intimate partner violence: A meta-analytic review. *Psychology of Violence*, 8(1), 110.

Cameron, B. L., del Pilar Carmargo Plazas, M., Santos Salas, A., Bourque Bearskin, L., & Hungler, K. (2014). Understanding inequalities in access to healthcare services for Aboriginal people: A call for nursing action. *Advances in Nursing Science*, 37(3).

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, 359(9314), 1331-1336.

Campbell, N. (2002). *Using women: Gender, drug policy, and social justice*. Routledge.

Canadian Centre on Substance Use and Addiction (CCSA). (2020). *Impacts of the COVID-19 pandemic on people who use substances: What we heard*. Retrieved from: https://www.ccsa.ca/sites/default/files/2020-07/CCSA-COVID-19-Impacts-on-People-Who-Use-Substances-Report-2020-en.pdf.

Canadian Centre on Substance Use and Addiction (CCSA). (2020). *Overcoming stigma through language: A primer*. Retrieved from: https://substanceuse.ca/sites/default/files/2021-03/CCSA-Language-and-Stigma-in-Substance-Use-Addiction-Guide-2019-en.pdf.

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. (2018). *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*.

Cachia, M., & Millward, L. (2011). The telephone medium and semi-structured interviews: a complementary fit. *Qualitative Research in Organizations and Management: An International Journal*.

Cardwell, M. S. (2013). Stress: pregnancy considerations. *Obstetrical & gynecological survey, 68*(2), 119-129.

CBC News. (2022). *Yukon declares substance use health emergency after 4 deaths in 1st week of January*. Retrieved from: https://www.cbc.ca/news/canada/north/yukon-substance-use-health-emergency-deaths-1.6321550.

Children's Aid Society of Toronto. (2015). Addressing disproportionality, disparity and discrimination in child welfare: Data on services provided to Black African Caribbean Canadian families and children. *Children's Aid Society of Toronto*. http://www.torontocas.ca/app/Uploads/documents/baccc-final-website-posting.pdf.

Coghlan, D., & Brydon-Miller, M. (2014). *The SAGE encyclopedia of action research* (Vols. 1-2). London: SAGE Publications Ltd. doi: 10.4135/9781446294406.

Collins, P. H. (2002). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. Routledge.

Contenta, S., Monsebraaten, L., & Rankin, J. (2014). *Why are so many black children in foster and group homes?* Retrieved from: https://www.thestar.com/news/canada/2014/12/11/why_are_so_many_black_children_in_foster_and_group_homes.html.

Cooley, C. H. (1902). *Human nature and the social order*.

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, *15*(2), 37-70.

Corrigan, P. W., Kuwabara, S. A., & O'Shaughnessy, J. (2009). The public stigma of mental illness and drug addiction: Findings from a stratified random sample. *Journal of Social Work*, *9*(2), 139-147.

Crenshaw, K. (1990). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stan. L. Rev.*, 43, 1241.

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illnesses. *The British Journal of Psychiatry*, *177*(1), 4-7.

Crisp, A., Gelder, M., Goddard, E., & Meltzer, H. (2005). Stigmatization of people with mental illnesses: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World Psychiatry*, *4*(2), 106.

Crowe, A., & Murray, C. E. (2015). Stigma from professional helpers toward survivors of intimate partner violence. *Partner Abuse*, *6*(2), 157-179.

Das Gupta, T. (1995). Families of native peoples, immigrants, and people of colour. *Canadian Families: Diversity, Conflict and Change*, 141-174.

Davis, K., & Yonkers, A. (2012). Making lemonade out of lemons: a case report and literature review of external pressure as an intervention with pregnant and parenting substance-using women. *The Journal of Clinical Psychiatry*, 73(1), 51.

Denison, J., Varcoe, C., & Browne, A. J. (2014). Aboriginal women's experiences of accessing healthcare when state apprehension of children is being threatened. *Journal of Advanced Nursing,* 70(5), 1105–1116.

Denning, P. (2001). Strategies for implementation of harm reduction in treatment settings. *Journal of Psychoactive Drugs,* 33(1), 23-26.

Desrosiers, A., Thompson, A., Divney, A., Magriples, U., & Kershaw, T. (2016). Romantic partner influences on prenatal and postnatal substance use in young couples. *Journal of Public Health*, *38*(2), 300-307.

Drabble, L., Trocki, K. F., Salcedo, B., Walker, P. C., & Korcha, R. A. (2016). Conducting qualitative interviews by telephone: Lessons learned from a study of alcohol use among sexual minority and heterosexual women. *Qualitative Social Work, 15*(1), 118-133.

Duggan, K. (2018). Health Canada expects mounting pressure to declare opioid crisis an emergency. *ipolitics.* Retrieved from: https://ipolitics.ca/2018/07/10/health-canada-expects-pressure-to-mount-to-declare-opioid-crisis-an-emergency/.

Dunt, D., Robinson, J., Selvarajah, S., Young, L., Highet, N., Shann, C., & Pirkis, J. (2011). beyondblue, Australia's National Depression Initiative: An Evaluation for the Period 20052010. *International Journal of Mental Health Promotion*, *13*(3), 22-36.

Ellard-Gray, A., Jeffrey, N. K., Choubak, M., & Crann, S. E. (2015). Finding the hidden participant: Solutions for recruiting hidden, hard-to-reach, and vulnerable populations. *International Journal of Qualitative Methods*, 14(5), 1609406915621420.

Enarson, E. (1999). Violence against women in disasters: A study of domestic violence programs in the United States and Canada. *Violence Against Women*, 5(7), 742-768.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4), 245-258.

Festinger, D. S., Marlowe, D. B., Croft, J. R., Dugosh, K. L., Mastro, N. K., Lee, P. A., & Patapis, N. S. (2005). Do research payments precipitate drug use or coerce participation? *Drug and Alcohol Dependence*, 78(3), 275-281.

Fineman, M. A. (2010). *The vulnerable subject: Anchoring equality in the human condition. In Transcending the boundaries of law* (pp. 177-191). Routledge-Cavendish.

Finnegan, L. (2013). Substance abuse in Canada: Licit and illicit drug use during pregnancy: Maternal, neonatal and early childhood consequences. Ottawa, ON, *Canadian Centre on Substance Abuse.*

First Nations Health Authority. (2021*). First Nations toxic drug deaths doubled during the pandemic in 2020.* Retrieved from: https://www.fnha.ca/about/news-and-events/news/first-nations-toxic-drug-deaths-doubled-during-the-pandemic-in-2020.

Fischer, B., Murphy, Y., Rudzinski, K., & MacPherson, D. (2016). Illicit drug use and harms, and related interventions and policy in Canada: A narrative review of select key indicators and developments since 2000. *International Journal of Drug Policy*, *27*, 23-35.

Friedman, S. H., Heneghan, A., & Rosenthal, M. (2009). Characteristics of women who do not seek prenatal care and implications for prevention. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 38(2), 174-181.

Fry, C. L., Hall, W., Ritter, A., & Jenkinson, R. (2006). The ethics of paying drug users who participate in research: A review and practical recommendations. *Journal of Empirical Research on Human Research Ethics*, 1(4), 21-35.

Gale Encyclopedia of Mental Disorders. (2003). Stigma. *Encyclopedia.com.* Retrieved from: https://www.encyclopedia.com/psychology/encyclopedias-almanacs-transcripts-and-maps/stigma.

Gamble, V. N. (1993). A legacy of distrust: African Americans and medical research. *American Journal of Preventive Medicine, 9*(6), 35-38.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Hawthorne, NY: Aldine.

Glenn, E. (1994). Social constructions of mothering: A thematic overview. In Glenn, E. N., Chang, G., & Forcey, L. R. (Eds.). (2016). *Mothering: Ideology, experience, and agency* (pp. 1-29). Routledge.

Glenn, E. N., Chang, G., & Forcey, L. R. (Eds.). (2016). *Mothering: Ideology, experience, and agency*. Routledge.

Goffman, E. (1977). The arrangement between the sexes. *Theory and Society*, 4(3), 301-331.

Goffman, E. (1963). *Stigma: Notes on the management of a spoiled identity*. New York: Simon & Schuster.

Gomes, T., Murray, R., Kolla, G., Leece, P., Bansal, S., & Besharah, J. (2021). Changing circumstances surrounding Opioid-Related deaths in Ontario during the COVID-19 pandemic. *Ontario: Ontario Drug Policy Research Network*.

Government of BC. (2022). *Joint statement on the six-year anniversary of B.C.'s overdose emergency.* Retrieved from: https://news.gov.bc.ca/releases/2022MMHA0020-000564.

Government of Canada. (2020). Coronavirus disease (COVID-19): *Vulnerable populations and COVID-19.* Retrieved from: https://www.canada.ca/en/public-health/services/publications/diseases-conditions/vulnerable-populations-covid-19.html.

Government of Canada. (2021). *COVID-19 daily epidemiology update*. Retrieved from: https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html.

Government of Canada. (2020). *Opioid-related harms in Canada.* Retrieved from: https://health-infobase.canada.ca/substance-related-harms/opioids.

Greaves, L., Varcoe, C., Poole, N., Morrow, M., Johnson, J., Pederson, A., & Irwin, L. (2002). *A motherhood issue: Discourses on mothering under duress* (pp. 1-147). Ottawa, ON: Status of Women Canada.

Hays, Sharon. 1996. *The cultural contradictions of motherhood*. New Haven, CT: Yale University Press.

Harm Reduction International. (Accessed 2021). Retrieved from: https://www.hri.global/what-is-harm-reduction.

Harvey, S., Schmied, V., Nicholls, D., & Dahlen, H. (2015). Hope amidst judgement: the meaning mothers accessing opioid treatment programmes ascribe to interactions with health services in the perinatal period. *Journal of Family Studies*, *21*(3), 282-304.

Haskell L. A developmental understanding of complex trauma. In: Poole N, Greaves L, eds. Becoming Trauma-Informed. Toronto, Canada: Centre for Addiction and Mental Health; 2013:9-27.

Health Canada. 2019. *About problematic substance use.* Retrieved from: https://www.canada.ca/en/health-canada/services/substance-use/about-problematic-substance-use.html#s2.

Hien, D., Litt, L. C., Cohen, L. R., Miele, G. M., & Campbell, A. (2009). *Trauma services for women in substance abuse treatment: An integrated approach*. American Psychological Association.

Henderson, S., Stacey, C. L., & Dohan, D. (2008). Social stigma and the dilemmas of providing care to substance users in a safety-net emergency department. *Journal of Health Care for the Poor and Underserved, 19*(4), 1336-1349.

Hengartner, M. P., Loch, A. A., Lawson, F. L., Guarniero, F. B., Wang, Y. P., Rössler, W., & Gattaz, W. F. (2013). Public stigmatization of different mental disorders: a comprehensive attitude survey. *Epidemiology and Psychiatric Sciences*, *22*(3), 269-274.

Herek, G. M., Capitanio, J. P., & Widaman, K. F. (2003). Stigma, social risk, and health policy: public attitudes toward HIV surveillance policies and the social construction of illness. *Health Psychology*, *22*(5), 533.

Herman, J. L., Kolk, B. A., & Van der Kolk, B. (1990). *Traumatic antecedents questionnaire.*

Hickie, I. (2001). Beyondblue: The national depression initiative. *Australasian Psychiatry*, *9*(2), 147-150.

Holt, A. (2010). Using the telephone for narrative interviewing: a research note. *Qualitative Research*, *10*(1), 113-121.

Howard, H. (2015). Reducing stigma: Lessons from opioid-dependent women. *Journal of Social Work Practice in the Addictions, 15*(4), 418-438.

Hunt, M. R. (2009). Strengths and challenges in the use of interpretive description: reflections arising from a study of the moral experience of health professionals in humanitarian work. *Qualitative Health Research*, *19*(9), 1284-1292.

Jackson, Kenneth. (2020). *'There is no timetable': Courts refuse to let these three moms see children during pandemic*. APTN National News.

Jennings, B. (2019). Relational ethics for public health: Interpreting solidarity and care. *Health Care Analysis*, 27(1), 4-12.

Jones, H. E., Tuten, M., & O'Grady, K. E. (2011). Treating the partners of opioid-dependent pregnant patients: feasibility and efficacy. *The American Journal of Drug and Alcohol Abuse*, *37*(3), 170-178.

Jorm, A. F., Jorm, A. F., Christensen, H., Griffiths, K. M., Jorm, A. F., Christensen, H., & Griffiths, K. M. (2005). The impact of beyondblue: the national depression initiative on the Australian public's recognition of depression and beliefs about treatments. *Australian & New Zealand Journal of Psychiatry*, *39*(4), 248-254.

Keddell, E., & Hyslop, I. (2019). Ethnic inequalities in child welfare: The role of practitioner risk perceptions. *Child & Family Social Work*, *24*(4), 409-420.

Kenny, K. S., & Barrington, C. (2018). “People just don't look at you the same way”: Public stigma, private suffering and unmet social support needs among mothers who use drugs in the aftermath of child removal. *Children and Youth Services Review*, *86*, 209-216.

Keyes, K. M., Grant, B. F., & Hasin, D. S. (2008). Evidence for a closing gender gap in alcohol use, abuse, and dependence in the United States population. *Drug and Alcohol Dependence*, 93(1-2), 21-29.

King, B., Fallon, B., Boyd, R., Black, T., Antwi-Boasiako, K., & O’Connor, C. (2017). Factors associated with racial differences in child welfare investigative decisionmaking in Ontario, Canada. *Child Abuse & Neglect*, 73, 89–105.

Knafl, K.A., & Webster, D.C. (1988). Managing and analyzing qualitative data: A description of tasks, techniques, and materials. *Western Journal of Nursing Research*, 10, 195–218.

King, T. (1990). *All my relations*. McClelland & Stewart.

Kofman, Y. B., & Garfin, D. R. (2020). Home is not always a haven: The domestic violence crisis amid the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(S1), S199.

Lawson, M., Piel, M. H., & Simon, M. (2020). Child maltreatment during the COVID-19 pandemic: Consequences of parental job loss on psychological and physical abuse towards children. *Child Abuse & Neglect*, *110*, 104709.

Lai, B. S., Osborne, M. C., Piscitello, J., Self-Brown, S., & Kelley, M. L. (2018). The relationship between social support and posttraumatic stress symptoms among youth exposed to a natural disaster. European Journal of Psychotraumatology, 9(Suppl 2), 1450042.*

Lee, H. S., & Zerai, A. (2010). "Everyone deserves services no matter what": Defining success in harm-reduction-based substance user treatment. *Substance Use & Misuse*, *45*(14), 2411-2427.

Lechuga, V. M. (2012). Exploring culture from a distance: The utility of telephone interviews in qualitative research. *International Journal of Qualitative Studies in Education*, *25*(3), 251-268.

Lincoln, Y., & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*(1), 363-385.

Link, B. G., & Phelan, J. (2014). Stigma power. *Social Science & Medicine*, *103*, 24-32.

Little, L.A. (2020). *North Bay emergency responders to stop using naloxone nasal spray during pandemic*. CTV News. Retrieved from: https://northernontario.ctvnews.ca/north-bay-emergency-responders-to-stop-using-naloxone-nasal-spray-during-pandemic-1.4881599.

Little, J., & Franskoviak, P. (2010). So glad you came! Harm reduction therapy in community settings. *Journal of Clinical Psychology*, *66*(2), 175-188.

Mackenzie, C., & Stoljar, N. (Eds.). (2000). *Relational autonomy: Feminist perspectives on autonomy, agency, and the social self*. Oxford University Press.

Madigan, S. (2011). *Narrative therapy*. American Psychological Association.

Mannarini, S., & Boffo, M. (2015). Anxiety, bulimia, drug and alcohol addiction, depression, and schizophrenia: what do you think about their aetiology, dangerousness, social distance, and treatment? A latent class analysis approach. *Social Psychiatry and Psychiatric Epidemiology*, *50*(1), 27-37.

Mak, W. W., Chan, R. C., Wong, S. Y., Lau, J. T., Tang, W. K., Tang, A. K., ... & Lee, D. T. (2017). A cross-diagnostic investigation of the differential impact of discrimination on clinical and personal recovery. *Psychiatric Services*, *68*(2), 159-166.

Manitoba Families. (2020). Annual Report. Retrieved from: https://www.gov.mb.ca/fs/about/pubs/fsar_2019-2020.pdf.

Marcellus, L., MacKinnon, K., Benoit, C., Phillips, R., & Stengel, C. (2015). Reenvisioning success for programs supporting pregnant women with problematic substance use. *Qualitative Health Research*, *25*(4), 500-512.

Marcellus, L., Marcellus, L., & Marcellus, L. (2004). Feminist ethics must inform practice: Interventions with perinatal substance users. *Health Care for Women International*, 25(8), 730-742.

Marcellus, L. (2014). Supporting women with substance use issues: trauma-informed care as a foundation for practice in the NICU. *Neonatal Network*, *33*(6), 307-314.

Marie, D., & Miles, B. (2008). Social distance and perceived dangerousness across four diagnostic categories of mental disorder. *Australian & New Zealand Journal of Psychiatry*, *42*(2), 126-133.

Maté, G. (2008). *In the realm of hungry ghosts: Close encounters with addiction*. Random House Digital, Inc.

Meaney, S., Leitao, S., Olander, E. K., Pope, J., & Matvienko-Sikar, K. (2021). The impact of COVID-19 on pregnant womens' experiences and perceptions of antenatal maternity care, social support, and stress-reduction strategies. *Women and Birth*.

Meixner, T., Milligan, K., Urbanoski, K., & McShane, K. (2016). Conceptualizing integrated service delivery for pregnant and parenting women with addictions: Defining key factors and processes. *Canadian Journal of Addiction*, *7*(3), 57-65.

McHugh, R. K., Wigderson, S., & Greenfield, S. F. (2014). Epidemiology of substance use in reproductive-age women. *Obstetrics and Gynecology Clinics*, 41(2), 177-189.

McLeod, C., & Sherwin, S. (2000). Relational autonomy, self-trust, and health care for patients who are oppressed.

McNeil, R., Kerr, T., Pauly, B., Wood, E., & Small, W. (2016). Advancing patient-centered care for structurally vulnerable drug-using populations: a qualitative study of the perspectives of people who use drugs regarding the potential integration of harm reduction interventions into hospitals. *Addiction*, *111*(4), 685-694.

Mendelson, J. (2017). Separated by a Hair. *A Toronto Star/CBC Investigation.* Retrieved from: https://projects.thestar.com/motherisk/.

Miller, L., Neathey, F., Pollard, E., & Hill, D. (2004). *Occupational segregation, gender gaps and skill gaps*. Manchester: Equal Opportunities Commission.

Milligan, K., Niccols, A., Sword, W., Thabane, L., Henderson, J., & Smith, A. (2011). Birth outcomes for infants born to women participating in integrated substance abuse treatment programs: A meta-analytic review. *Addiction Research & Theory*, 19(6), 542-555.

Milligan, K., Niccols, A., Sword, W., Thabane, L., Henderson, J., & Smith, A. (2011). Length of stay and treatment completion for mothers with substance abuse issues in integrated treatment programmes. *Drugs: Education, Prevention and Policy,* 18(3), 219-227.

Milligan K, Usher AM, & Urbanoski, KA. (2017). Supporting pregnant and parenting women with substance-related problems by addressing emotion regulation and executive function needs. *Addiction Research & Theory*, 25(3), 251-261.

Mitchell, G.J., & Cody, W.K. (1993). The role of theory in qualitative research. *Nursing Science Quarterly*, 6, 170–178.

Mohamud, F., Edwards, T., Antwi-Boasiako, K., William, K., King, J., Igor, E., & King, B. (2021). Racial disparity in the Ontario child welfare system: Conceptualizing policies and practices that drive involvement for Black families. *Children and Youth Services Review*, *120*, 105711.

Motz, M., Leslie, M., Pepler, D., Moore, T. E., & Freeman, P. A. (2006). Breaking the Cycle: Measures of progress. *Journal of Fetal Alcohol Syndrome International*, *4*, e22.

Murray, C. E., Crowe, A., & Brinkley, J. (2015). The stigma surrounding intimate partner violence: A cluster analysis study. *Partner Abuse*, *6*(3), 320-336.

Mushtaq, S., Mendes, V., Nikolaou, V., & Luty, J. (2015). Analysis of the possible components of stigmatised attitudes towards depression and heroin dependence. *Journal of Substance Use*, *20*(6), 399-406.

Nanos. (2020). COVID-19 and Increased Alcohol Consumption: NANOS Poll Summary Report. *Canadian Centre on Substance Use and Addiction.*

National Center on Addiction and Substance Abuse, Columbia University. (2003). *The formative years: Pathways to substance abuse among girls and young women ages 8-22. CASA.*

National Treatment Strategy Working Group. (2008). *A systems approach to substance use in Canada: recommendations for a national treatment strategy*. Retrieved from: www.ccsa.ca/Resource%20Library/nts-systemsapproach-substance-abuse-canada-2008-en.pdf.

Neria, Y., Olfson, M., Gameroff, M. J., Wickramaratne, P., Gross, R., Pilowsky, D. J., ... & Weissman, M. M. (2008). The mental health consequences of disaster-related loss: findings from primary care one year after the 9/11 terrorist attacks. *Psychiatry: Interpersonal and Biological Processes*, *71*(4), 339-348.

Niccols, A., Milligan, K., Sword, W., Thabane, L., Henderson, J., Smith, A., & Jack, S. (2010). Maternal mental health and integrated programs for mothers with substance abuse issues. *Psychology of Addictive Behaviors,* 24(3), 466.

Norris, F. H., Friedman, M. J., Watson, P. J., Byrne, C. M., Diaz, E., & Kaniasty, K. (2002). 60,000 disaster victims speak: Part I. An empirical review of the empirical literature, 1981–2001. *Psychiatry: Interpersonal and biological processes, 65*(3), 207-239.

Nurse, J., Dorey, S., Yao, L., Sigfrid, L., Yfantopolous, P., McDaid, D., & Moreno, J. M. (2014). *The case for investing in public health: a public health summary report for EPHO 8.*

Oakley, A. (1981) 'Interviewing women: a contradiction in terms', in H. Roberts (ed.) *Doing Feminist Research*, London: Routledge.

Olivetti, C., & Petrongolo, B. (2017). The economic consequences of family policies: lessons from a century of legislation in high-income countries. *Journal of Economic Perspectives, 31*(1), 205-30.

Ontario Human Rights Commission. (2018). Interrupted childhoods: Over-representation of Indigenous and Black children in Ontario child welfare. *Toronto: Queen's Printer for Ontario*.

Overall, C. (1993). *Human reproduction: Principles, practices, policies.*

Panchal, N., Kamal, R., Orgera, K., Cox, C.; Garfield, R., Hamel, L., Munana, C.; Chidambaram, P. (2020). *Kaiser Family Foundation.* The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Retrieved from https://www.kff.org/health-reform/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.

Patton, M. Q. (2002). Qualitative interviewing. *Qualitative Research and Evaluation Methods,* 3(1), 344-347.

Pauly, B. (2014). Close to the street: nursing practice with people marginalized by homelessness and substance use. *Homelessness and health in Canada*, 211.

Pauly, B. B., McCall, J., Browne, A. J., Parker, J., & Mollison, A. (2015). Toward cultural safety. *Advances in Nursing Science*, *38*(2), 121-135.

Peckover, S., & Chidlaw, R. G. (2007). Too frightened to care? Accounts by district nurses working with clients who misuse substances. *Health & Social Care in the Community*, *15*(3), 238-245.

Pescosolido, B. A., Monahan, J., Link, B. G., Stueve, A., & Kikuzawa, S. (1999). The public's view of the competence, dangerousness, and need for legal coercion of persons with mental health problems. *American Journal of Public Health*, *89*(9), 1339-1345.

Pfefferbaum, B., & North, C. S. (2020). Mental health and the Covid-19 pandemic. *New England Journal of Medicine*, *383*(6), 510-512.

Rachelle Pelletier, R., Patterson, M., & Moyser, M. (2019). The gender wage gap in Canda: 1998-2018. *Statistics Canada.* Retrieved from: https://www150.statcan.gc.ca/n1/en/pub/75-004-m/75-004-m2019004-eng.pdf?st=YyUWG6AF.

Pepler, D. J., Moore, T. E., Motz, M., & Leslie, M. (2002). Breaking the cycle: The evaluation report (1995–2000). Toronto: *Breaking the Cycle*.

Public Health Agency of Canada. (2016). *The direct economic burden of socio-economic health inequalities in Canada: An analysis of health care costs by income level*. PHAC.

Poole, N., & Isaac, B. (2001). *Apprehensions: barriers to treatment for substance-using mothers.* British Columbia Centre of Excellence for Women’s Health: Vancouver, Canada.

Powell, A. (2020). Rising mental health concerns in the coronavirus era. The Harvard Gazette. Retrieved from: https://news.harvard.edu/gazette/story/2020/04/rising-mental-health-concerns-in-the-coronavirus-era/.

Priester, M. A., Browne, T., Iachini, A., Clone, S., DeHart, D., & Seay, K. D. (2016). Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: an integrative literature review. *Journal of Substance Abuse Treatment*, *61*, 47-59.

Roberts, D. (2009). *Shattered bonds: The color of child welfare*. Civitas Books.

Rueda, S., Mitra, S., Chen, S., Gogolishvili, D., Globerman, J., Chambers, L., & Rourke, S. B. (2016). Examining the associations between HIV-related stigma and health outcomes in people living with HIV/AIDS: a series of meta-analyses. *BMJ open*, *6*(7), e011453.

Ruddick, S. (2004). *Maternal thinking* (pp. 216-230). Duke University Press.

Sacco, M. A., Caputo, F., Ricci, P., Sicilia, F., De Aloe, L., Bonetta, C. F., ... & Aquila, I. (2020). The impact of the Covid-19 pandemic on domestic violence: the dark side of home isolation during quarantine. *Medico-Legal Journal*, *88*(2), 71-73.

Sanders, J., & Blaylock, R. (2021). "Anxious and traumatised": Users' experiences of maternity care in the UK during the COVID-19 pandemic. *Midwifery, 102, 103069*.

Saura, D. M., & Balsas, P. R. (2014). Interviewing and surveying over the phone: A reflexive account of a research on parenting. *Quality & Quantity, 48*(5), 2615-2630.

Schempf, A. H. (2007). Illicit drug use and neonatal outcomes: *A critical review. Obstetrical and Gynecological Survey*, 62(11), 749–757.

Seedat, S., Scott, K. M., Angermeyer, M. C., Berglund, P., Bromet, E. J., Brugha, T. S., ... & Kessler, R. C. (2009). Cross-national associations between gender and mental disorders in the World Health Organization World Mental Health Surveys. *Archives of General Psychiatry, 66*(7), 785-795.

Shanner, L. (1998). Pregnancy intervention and models of maternal-fetal relationship. *Alberta Law Review*, 36(3), 751–767.

Sherwin, S. (2000). A relational approach to autonomy in health care. *Readings in Health Care ethics*, 57-68.

Smith, C. L., Waters, S. F., Spellacy, D., Burduli, E., Brooks, O., Carty, C. L., ... & Barbosa-Leiker, C. (2021). Substance use and mental health in pregnant women during the COVID-19 pandemic. *Journal of Reproductive and Infant Psychology, 1-14*.

Smith, C. A., Elwyn, L. J., Ireland, T. O., & Thornberry, T. P. (2010). Impact of adolescent exposure to intimate partner violence on substance use in early adulthood. *Journal of Studies on Alcohol and Drugs*, 71(2), 219-230.

Sorsdahl, K. R., & Stein, D. J. (2010). Knowledge of and stigma associated with mental disorders in a South African community sample. *The Journal of nervous and mental disease, 198*(10), 742-747.

Sorsdahl, K., Stein, D. J., & Myers, B. (2012). Negative attributions towards people with substance use disorders in South Africa: Variation across substances and by gender. *BMC psychiatry*, *12*(1), 1-8.

Statistics Canada. (2016). *Reducing the number of Indigenous children in care*. Retrieved from: https://www.sac-isc.gc.ca/eng/1541187352297/1541187392851.

Statistics Canada. (2019). *Causes of death, 2017*. Retrieved from: https://www150.statcan.gc.ca/n1/daily-quotidien/190530/dq190530c-eng.htm.

Stephen Gaetz, Bill O'Grady, Sean Kidd & Kaitlin Schwan. (2016). *Without a Home: The National Youth Homelessness Survey.* Toronto: Canadian Observatory on Homelessness Press.

Stein, A., Pearson, R.M., Goodman, S.H., Rapa, E., Rahman, A., McCallum, M., Howard, L.M., & Pariante, C.M. (2014). Effects of perinatal mental disorders on the fetus and child. *The Lancet, 384*(9956), 1800-1819.

Steingrímsson, S., Carlsen, H. K., Sigfússon, S., & Magnússon, A. (2012). The changing gender gap in substance use disorder: A total population-based study of psychiatric in-patients. *Addiction*, *107*(11), 1957-1962.

Sweet, L. (2002). Telephone interviewing: is it compatible with interpretive phenomenological research?. *Contemporary Nurse*, *12*(1), 58-63.

Sword, W., Jack, S., Niccols, A., Milligan, K., Henderson, J., & Thabane, L. (2009). Integrated programs for women with substance use issues and their children: a qualitative meta-synthesis of processes and outcomes. *Harm Reduction Journal*, 6(1), 32.

Suhrcke M, Sauto Arce R, McKee M, Rocco L. Economic Costs of Ill Health in the European Region. *Geneva: World Health Organization*, 2008.

Sun, A. P. (2000). Helping substance-abusing mothers in the child-welfare system: Turning crisis into opportunity. *Families in Society*, *81*(2), 142-151.

Tarasoff, L. A., Milligan, K., Le, T. L., Usher, A. M., & Urbanoski, K. (2018). Integrated treatment programs for pregnant and parenting women with problematic substance use: Service descriptions and client perceptions of care. *Journal of Substance Abuse Treatment*, 90, 9-18.

Tatarsky, A. (2003). Harm reduction psychotherapy: Extending the reach of traditional substance use treatment. *Journal of Substance Abuse Treatment*, *25*(4), 249-256.

Thomson, N. (2021). Domestic violence reports continue to rise due to COVID-19 pandemic. *CP24*. Retrieved from: https://www.cp24.com/news/domestic-violence-reports-continue-to-rise-due-to-covid-19-pandemic-1.5309133.

Thorne, S., Kirkham, S. R., & MacDonald-Emes, J. (1997). Interpretive description: a noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health*, 20(2), 169-177.

Thorne, S. (2016). *Interpretive description: Qualitative research for applied practice*. Second Edition. Routledge.

Thumath, M., Humphreys, D., Barlow, J., Duff, P., Braschel, M., Bingham, B., ... & Shannon, K. (2021). Overdose among mothers: the association between child removal and unintentional drug overdose in a longitudinal cohort of marginalised women in Canada. *International Journal of Drug Policy*, *91*, 102977.

Tolan, C. (2020, April 4). Some cities see jumps in domestic violence during the pandemic. CNN. Retrieved from https://www.cnn.com/2020/ 04/04/us/domestic-violence-coronavirus-calls-cases-increase-invs/ index.html.

Trier-Bieniek, A. (2012). Framing the telephone interview as a participant-centred tool for qualitative research: a methodological discussion. *Qualitative Research*, *12*(6), 630-644.

Trocmé, N., Fallon, B., Sinha, V., Van Wert, M., Kozlowski, A., & MacLaurin, B. (2013). Differentiating between child protection and family support in the Canadian child welfare system's response to intimate partner violence, corporal punishment, and child neglect. *International Journal of Psychology*, *48*(2), 128-140.

Turner, A. (2016). Insights on Canadian society: Living arrangements of Aboriginal children aged 14 and under. Statistics Canada. Retrieved from: https://www150.statcan.gc.ca/n1/pub/75-006-x/2016001/article/14547-eng.htm.

UNAIDS. (2010). *An introduction to triangulation*. UNAIDS Monitoring and Evaluation Fundamentals. Retrieved from: https://www.unaids.org/sites/default/files/sub_landing /files/10_4-Intro-to-triangulation-MEF.pdf.

Urbanoski, K., Inglis, D., & Veldhuizen, S. (2017). Service use and unmet needs for substance use and mental disorders in Canada. *The Canadian Journal of Psychiatry, 62*(8), 551-559.

Urbanoski, K., Joordens, C., Kolla, G., & Milligan, K. (2018). Community networks of services for pregnant and parenting women with problematic substance use. *PloS one*, 13(11), e0206671.

Urbanoski, K., Merrigan, S., & Milligan, K. (2021). Gendered harms: the lack of evidence on treatment that is mandated by child protection services. *International Journal on Drug Policy*, *99*, e103481-e103481.

van Boekel, L. C., Brouwers, E. P., van Weeghel, J., & Garretsen, H. F. (2013). Public opinion on imposing restrictions to people with an alcohol-or drug addiction: a cross-sectional survey. *Social Psychiatry and Psychiatric Epidemiology*, *48*(12), 2007-2016.

Van der Kolk, B. A. (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Penguin Books.

Walshaw, M. (2008). *The concept of identity positioning the self within research*. Paper presented at the ICME11, Mexico.

West, C., & Zimmerman, D. H. (1987). Doing gender. *Gender & Society*, 1(2), 125-151.

Wilson, S. (2008). *Research is ceremony: Indigenous research methods*. Fernwood Publishing.

Wong, J. Y. (2009). Understanding and utilizing parallel processes of social interaction for attachment-based parenting interventions. *Clinical Social Work Journal*, *37*(2), 163-174.

Wright, A., & Walker, J. (2007, April). Management of women who use drugs during pregnancy. In *Seminars in fetal and neonatal medicine* (Vol. 12, No. 2, pp. 114-118). WB Saunders.

Yang, L., Wong, L. Y., Grivel, M. M., & Hasin, D. S. (2017). Stigma and substance use disorders: an international phenomenon. *Current Opinion in Psychiatry*, *30*(5), 378.

Yap, M. B., Reavley, N. J., & Jorm, A. F. (2012). Associations between awareness of beyondblue and mental health literacy in Australian youth: Results from a national survey. *Australian & New Zealand Journal of Psychiatry*, *46*(6), 541-5

Appendices

Appendix A: Interview Guide

HOW IS STIGMA INTERNALIZED, ANTICIPATED, AND EMBODIED?

Interview Guide 2: Experiences Accessing Support

Thank you for agreeing to speak with me about your experiences during COVID19 and the ways in which your life and experiences are similar or different. With this interview we are hoping to learn a little bit more about your experience accessing services for substance use and understand how getting support has been different since COVID19. There are no right or wrong ways of answering and you can feel free to share as much or as little as you wish. The interview will last about 25-30 minutes and we can take a break at any time – just let me know.

In the last interview we talked about your wellbeing during COVID as well as mothering experiences, so this interview will dive a bit deeper into your mental health and your experiences getting support for mental health and/or substance use, and talk a little bit about your social support network.

My first question is:

Self-esteem

1. How have you been feeling about yourself these past few months? In other words, what kinds of things have been affecting your self-esteem?

Probes:

In what ways has your self-esteem impacted your day-to-day life? (self-care)

If negative:

Have you hesitated or given up doing something because of these problems? (Housekeeping, parenting, decision making, getting in touch with friends and family, education, finding a job, keeping a job, school)

If positive:

What makes you feel most confident in yourself and your abilities?

My next question pertains to any support you might have received during this time, specifically for substance use or for your mental health in general.

Accessing Formal and Informal Supports

2. Can you tell me about your experiences accessing services for substance use (or mental health broadly speaking) during the pandemic, whether formal or informal? (harm reduction services, support groups, self-help meetings, inpatient/outpatient substance use treatment programs, counselling, doctor visits, friends/family)
   If not in substance use treatment currently: If you can recall back, can you tell me about your experiences accessing services for substance use when you were first starting your recovery?

Probes:
What have been the most positive aspects of reaching out for support? Did you get the care you were seeking?
What have been the most challenging aspects of reaching out for support? (i.e. navigating the system, not knowing where to go, negative experiences)
 How did these experiences make you feel?
 How have these challenges impacted your desire to seek help in the future?
Has there ever been a time when you wanted to get treatment or access support, but didn't?
 What barriers did you encounter?
 Have others ever discouraged you from seeking support? How did you feel about it?
Have you ever used or had an interest in accessing online/virtual services? (i.e. Telehealth, mental health hotlines, e-counselling, online support groups)
 Have you encountered any barriers to either finding or accessing online supports?

My next question is about your relationships during this time.

Relationships with Others

3. Who has been your biggest support system during COVID19?

Probes:
In what ways do they help you?
What qualities do you value most in your friends?
Tell me more about your relationship with your family/partner/spiritual or religious affiliations/neighbours/colleagues/health care providers/child welfare case worker.
Has COVID-19 impacted your ability to communicate with loved ones in times of need? In what ways?
Are there any relationships that you would like to be stronger?

4. As a mother, what do you need to feel supported in your recovery, during this time or in general?

Probes:
From your friends and family?
From social service workers and health care providers?
What do you wish people would understand about mothering and substance use?

Closing Questions

We have reached the end of the interview.

Is there anything you would like to tell me that we have not already discussed?

Appendix B: Consent Form

INFORMED CONSENT AGREEMENT
Follow-up Qualitative Study

Study Title: Healthy Mothers Healthy Families: Maternal Substance Use, Executive Functions and Parenting

Principal Investigator:

Karen Milligan, Ph.D., Associate Professor, Department of Psychology, Ryerson University, 416-979-5000 ext. 7054, karen.milligan@ryerson.ca

Additional Investigators for this Specific Study:

Karen Urbanoski, PhD., Scientist, Canadian Institute for Substance Use Research, Associate Professor, University of Victoria, urbanosk@uvic.ca

Graduate Student Investigator:

Emily Nichol, Social Dimensions of Health, University of Victoria, emilyjnichol@uvic.ca. Interview data will be used to support completion of a Master's thesis.

Funding:

This study is supported by funding from the Ryerson Faculty of Arts Special Projects Grant and the Canadian Institutes of Health Research.

Why are we completing this study? While COVID19 and the public health response has changed the lives of all Canadians, the experience is not universal. This study will document the experiences of mothers who experience problematic substance use and other challenges to their health and wellness. Some of the experiences may be new, while others may be familiar to you. Some experiences may have improved or stayed the same, while other challenges may be harder. We are interested in hearing any these experiences – *your* COVID19 story. This information will be examined, along with data collected at the two earlier timepoints to help understanding the relation between stress and maternal problem-solving skills and mental health. This will help us in better understanding how to support mothers during times like this, and other times too.

What will you be asked to do? If you agree to participate, you will be asked to participate in an audiotaped phone interview about your experience during COVID19 and how this differs from before this time. This will include questions about your health and wellness and that of your children, parenting, and your experiences of accessing informal and formal supports and will last 30-45 minutes. There are two different interviews and you can choose to complete one or both (at the same time or at different times).

What are this risks? Participation in this research carries minimal risk. The researcher leading the call will ensure a climate of respect, non-judgment, and confidentiality. It is your choice how much information about your experiences you want to share. You may experience some distress when thinking about and sharing information about challenges. Finding a space to speak that is private and safe may be a challenge for some women. We will speak with you about how best to support a safe and comfortable experience for you. We can also reschedule the interview at any time, even after the interview has begun. A list of free services that may be helpful for you or your family is attached at the end of this consent.

Is what I share confidential? The information you share is **confidential. However, be aware that as researchers have certain legal obligations.** Similar to health providers if we hear information that leads to concern about child abuse, neglect, or harm or harm to you or someone else, we will have to share this information with the appropriate authorities. This is the only time that confidentiality would be broken and information would be shared.

What will happen to information collected? All information collected, including this consent agreement, questionnaires, and audio-recordings, will be stored on a password protected computer and physical notes and materials will be stored in a locked filing cabinet at Ryerson University in the Child Self-Regulation Laboratory. All names and other identifying information that might be obtained during recording will be deleted and symbols will be used. Only the research team members directly involved in this study will have access to this information collected. All records will be retained for seven years after the completion of this project at which time all information collected as part of this study will be destroyed. Audio-recordings will be typed out by a research team member within 2 weeks of the interview and then destroyed.

How will results be shared? Your story will be combined with the stories of approximately 20 other women. We will look for common experiences and we will present the information as a group and in a way that ensures you cannot be identified. The results of this research will be used to create reports and presentations to educate those in the system that support mothers.

Information will be presented in professional journals and websites, such as the Canadian Centre on Substance Use and Addiction.

Will I be compensated? You will receive a $30 gift card for Walmart or a $30 bank e-transfer for participating in each of the interviews (your choice), for a total of $60 for both interviews. If you decide you want to stop the interview, you can do so at any time and still receive this compensation.

How will this benefit me? You may not benefit personally from participating. However, by sharing your story you will help us better understand the experiences of mothers in COVID19 and the types of supports needed now and more generally as well.

Do I have to participate? Participation in this study is completely voluntary. Your choice of whether or not to participate will not influence your future relations Ryerson University or the University of Victoria. If you decide to participate, you can stop the interview at any time and can also ask to have your information excluded from the study. To do so, please contact Dr.

Milligan (416-979-5000 ext. 7054, karen.milligan@ryerson.ca).

Conflict of Interest:

There are no conflicts of interest to report for this study.

Questions about the Study:

If you have any questions about the research now, please ask. If you have questions later about the research, you may contact Dr. Karen Milligan; karen.milligan@ryerson.ca; 416-979-5000 ext. 7054; Associate Professor; Ryerson University, Psychology
This study has been reviewed by the Ryerson University Research Ethics Board REB: 2017-107. If you have questions regarding your rights as a participant in this study, please contact:

Research Ethics Board
c/o Office of the Vice President, Research and Innovation
Ryerson University
350 Victoria Street
Toronto, ON M5B
2K3 416-979-5042
rebchair@ryerson.ca

Additionally, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

CONSENT TO PARTICIPATE:

I have read/this consent form has been read to me and I understand that:

- All the information I provide will be kept confidential
- I can withdraw from the study at any time

I consent to completing the research session as outlined.

Interview 1__________ **Interview 2__________**

Agree

Disagree

CONSENT TO AUDIOTAPE

We are asking for your permission to audiotape the discussion. This is required to participate in this study. We will record on a digital audio recorder with the recording immediately saved to the secure server (“labshares”) at Ryerson University.

The recordings will be transcribed immediately and will only be accessible to research team members directly involved in transcribing. All recordings will be destroyed after they are typed, 2 weeks after the date of recording. All identifying information will be removed from the transcript so that it cannot be linked back to you. Recordings will not be used for any other reasons than the ones stated on this form.

I consent to being audio-taped.

Interview 1__________ **Interview 2__________**

Agree

Disagree

Free Supports for Women and Families

Mental Health and Addiction

Connex Ontario: call 1-866-531-2600 to find out where to access mental health, addictions and problem gambling support across Ontario.

House of Sophrosyne – Treatment agency in Windsor Ontario that is providing treatment services by phone and video for adults across Ontario. They have expertise in substance use and trauma and specific programming for mothers and young children. https://sophrosyne.ca/covid-19-program-schedule- changes/, 519-252-2711 X 115

Support Lines **Gerstein Crisis Centre**

http://gersteincentre.org/

416-929-5200

Hours: 24 hrs/7 days a week

Assaulted Women's Helpline 416-863-0511 or 1-866-863-0511

Indigenous Hope for Wellness 24 Hr Helpline 1-855-242-3310

Talk 4 Healing – Indigenous Women 24Hr Helpline 1-855-554-4325

Overdose Prevention Line 1-888-853-8542

Parenting

Mental Health Toronto (referral support to connect you with children's mental health/parenting support)

www.mentalhealthto.ca 1-866-585-6486

Community Mental Health Ontario – listing of local community mental health agencies (many offering telehealth). https://cmho.org/covid19/

COVID19 Parenting Tips: https://www.aboutkidshealth.ca/COVID-19

Other Resources

211 Ontario: For information and referrals for community, government, social and health services, including mental health resources across Ontario call 211 or 1-877-330-3213.

Food

Up-to-date information on food banks, delivery and take-away meals is available at

211 Ontario Daily Bread Food Bank: https://www.dailybread.ca/ | 416-203-0050

Meals-on-wheels: http://www.mealsonwheels.ca/ - Check website for local agency

Legal Aid

Ontario Steps to Justice - frequently asked questions about legal rights related to COVID-19: www.stepstojustice.ca/covid-19

Housing

https://www.ontario.ca/page/affordable-housing-

ontario Emergency shelter: 1-877-330-3213

Appendix C: Information Letter

Follow-up Research Recruitment Invitation

Dear (Name of Executive Director):

Thank you for assisting with recruitment for the first phase of our research study that examined problem-solving skills, maternal well-being and parenting in women who are engaged with services to address their substance use.

In our first phase of the research we were able to work with approximately 70 women from eight maternal substance use treatment programs. In doing this research, we learned a lot about the experience of women, including complex and varied mental health challenges (such as trauma, anxiety, depression, substance use) and high levels of stress associated with access to basic needs. We also saw that many women have strengths related to problem-solving (on tasks we completed with them) but that these mental health and socioeconomic stressors impact on these problem-solving skills. This can be associated with increased levels of parenting stress, including perception of oneself as a parent and challenges in caregiving related to behaviour and managing household organization and stress.

COVID-19 has had a significant impact on Canadians, however the direct and indirect impact of the pandemic has been particularly challenging for those who were already living in poverty or experiencing other risks related to their physical, mental, and social well-being.

We had the opportunity to follow-up with some of the women we met with in Phase 1 to talk about their experience during COVID-19. Many of these women reported that they were no longer in substance use treatment. Many were also no longer child welfare involved and had children who were 4 years and older. This means that we are missing women who are still participating in substance use treatment who have younger children. We believe that it is crucial that we capture the experiences of this group so that we can support these women and their families by sharing their needs, strengths, and stories and help inform ways to improve tailored and equitable access to supports needed to promote their well-being.

What are we asking of your agency?

If you are willing, we would ask that you post the following poster and/or send the digital poster to clients who have children under the age of 4 years. They may be current or past clients. Women who are involved with child welfare are welcome to participate, regardless of how often they see their children. The poster and the consent form are attached for more information. This study has been approved by the Research Ethics Boards of Ryerson University and the University of Victoria.

How will women get connected to the study?

If they are interested, they can click on the link in the digital study poster and be taken to a confidential survey or they can call or text our research coordinator, Laura Herman.

What will women be asked to do?

We have broken the study up into three parts, and women can complete whichever parts and as many parts as they would like. The first part involves completion of online questionnaires (approximately 30-40 minutes, they can take breaks and return as needed). The second and third parts are qualitative phone interviews (35-45 minutes each depending on how much they wish to share) asking them questions about their experience during the pandemic (and that of their children) and their experience in accessing supports. They can complete these at a time that is convenient for them. They will require access to a phone/internet to participate in the interview or questionnaire parts.

Will women receive any benefit or be compensated for their time?
Women will receive $30 for each interview ($60 for both) and $20 for completing the questionnaires.

Will our program receive any benefit?
Upon completion, we will share study results (presented across all women) with your agency. This information will help support the need for continued development of services for this population and ongoing research.

Thank you for your consideration. Please reach out if you have any questions.

Karen Milligan, Ph.D., C. Psych.
Associate Professor, Ryerson University
Director, Child and Family WISE (Wellness through Integrated Systems and Evaluation) Lab
karen.milligan@ryerson.ca

Appendix D: Recruitment Poster

Are you a mother of a child under age 4?

Have you attended substance use treatment (now or in the past)?

We want to learn about your experiences during COVID-19.

You can choose one or both of the following activities to participate in.

1. **Online survey** (or phone survey) about your well-being and parenting (30-40 minutes).

2. **Phone interview** about your experiences accessing supports and the well-being of yourself and your family during COVID-19 (choice of 1 or 2 interviews, 30-45 minutes each).

You will receive $20 for completing the survey and $30 for completing each phone interview (by bank e-transfer or a Walmart gift card).

Participation in this study is completely voluntary and your treatment agency will not be told your responses or about your choice of participation.

Click Here
to choose the activities you want to participate in and to send us your contact information.

For more information, please **call, text or email** Laura, Study Coordinator of the Child and Family WISE lab at Ryerson University, at **416-500-2577** cfwise@ryerson.ca

We look forward to hearing from you!

This study has been approved by the research ethics boards at Ryerson University (2017-107, rebchair@ryerson.ca) and University of Victoria (ethics@uvic.ca).