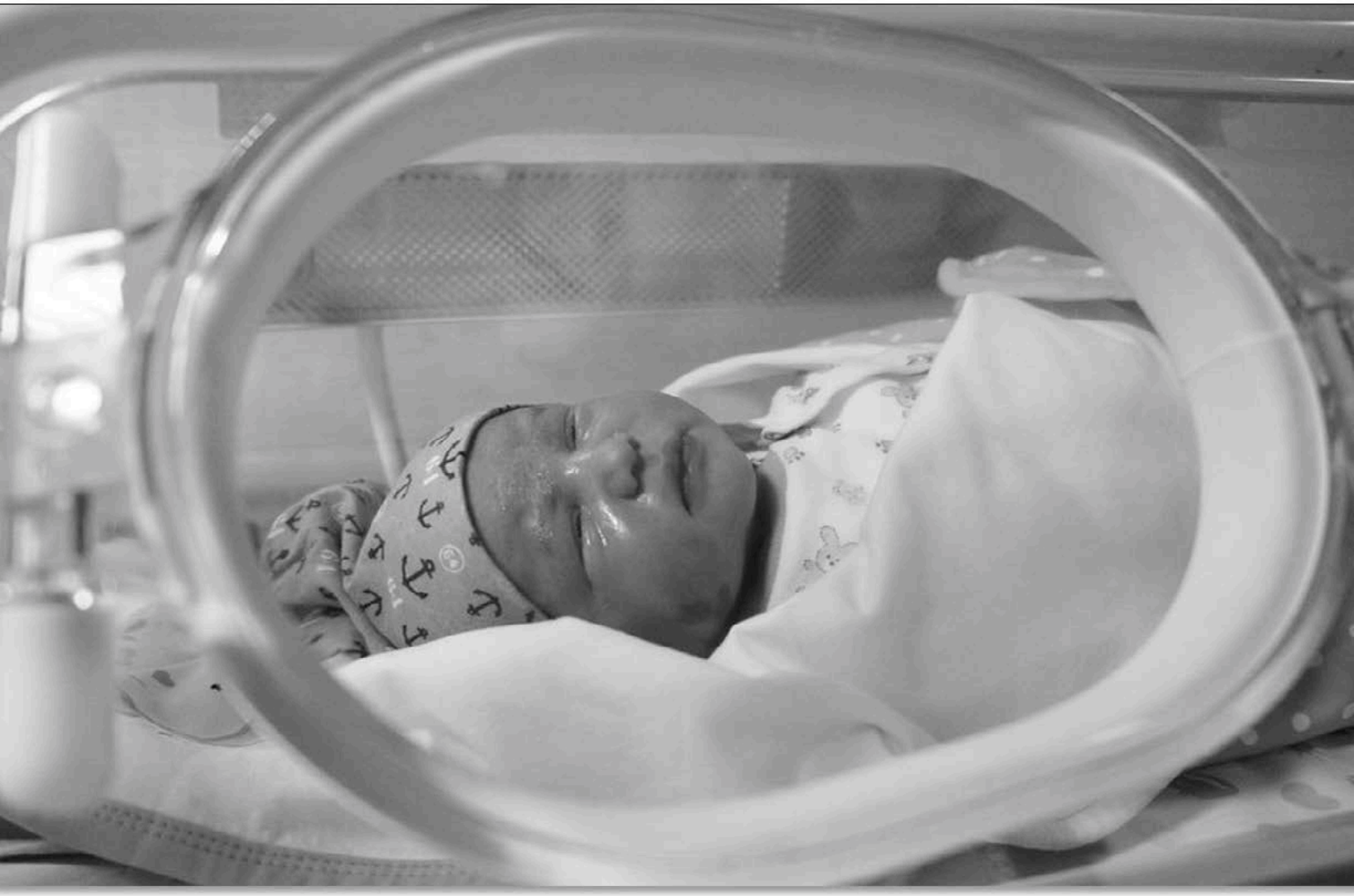
The Efficacy of Birth Alerts

Literature Scan



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POLICY BENCH

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Acronyms

APTN	Aboriginal Peoples Television Network
ASSIA	Applied Social Sciences Index and Abstracts
BC	British Columbia
CAS	Children's Aid Society
CFS	Child and Family Services (Manitoba)
COVID-19	Coronavirus-19
CYFA	Children, Youth and Families Act (Newfoundland and Labrador)
DCSSD	Department of Children, Seniors and Social Development (Newfoundland and Labrador)
eMR	electronic medical record
ERIC	Education Resources Information Center
FAC	Family and Children's Services
LHD	Local Health District
LS	Literature Scan
MCFD	Ministry of Children and Family Development (British Columbia)
MMIWG	Missing and Murdered Indigenous Women and Girls (Canada)
n.d.	No date
n.p.	No page number
NNSW LHD	Northern New South Wales Local Health District
NNSW	Northern New South Wales
NSW	New South Wales
OHRC	Ontario Human Rights Commission
TRC	Truth and Reconciliation Commission (Canada)
VCA	Voluntary Care Agreement

Executive Summary

Issue: The efficacy of birth alerts for purposes of child protection in Canada.

Background: In Canada, the practice of birth alerts has garnered considerable debate among child welfare advocates, practitioners, legal professionals and professional child welfare organizations regarding their efficacy in ensuring the safety and well being of children. Typically issued by child welfare workers without a mother's knowledge, birth alerts flag expectant mothers whose newborn may be at risk for harm, often resulting—but not always—in the traumatic apprehension of the newborn immediately after birth. The issue is of importance for two central reasons. First, decisions informed by birth alerts can have a lifelong impact on the lives of both children and parents. Failure to adequately assess a caregiver's potential to parent runs the risk of harming the child by either removing the child prematurely from a family or by subjecting the child to continued harm if returned to the family. Second, compared to other developed countries, Canada has an exceptionally high rate of children in care and a disproportionate number of Indigenous children in care.

Methods: A scan of existing peer reviewed and grey literature was carried out to identify, collect and synthesize research assessing the efficacy of birth alerts in Canada. The process involved a series of steps that included: the identification of key words/search terms; the identification of relevant data sources; the development of search strategies; an extensive and detailed search of peer reviewed and grey literature; literature screening and data extraction; and a synthesis of the literature. A list of keywords/search terms was developed that included the following: birth alert; birth apprehensions; apprehended at birth; and taken into care at birth. Throughout the search process, keywords/search terms were added, deleted or modified as different terms were discovered to enhance the search strategy. Search strategies were developed to meet the specifications and search parameters of each unique database. Pertinent information was extracted from the literature, synthesized and presented in tabular form.

Results/Findings: The results of the scan reveal limited evidence based research assessing the efficacy of birth alerts. Although the characterization of birth alerts as "problematic" and growing disapproval of birth alerts were common themes, supporting literature has largely been exploratory in nature and untested, requiring rigorous and systematic testing before any results can be used for guidance and decision-making. The profound effects birth alerts can have on the health and well being of children and families—particularly those of marginalized populations such as Canada's Indigenous peoples—demands greater cooperation and coordination between policymakers, practitioners and researchers, all of whom play a central role in supporting evidence-informed policy making.

The Efficacy of Birth Alerts
Literature Scan

1.0 Introduction

Canada's decentralized child welfare system consists of over 400 provincial and territorial child welfare agencies, operating under the jurisdiction of 13 provinces and territories (Trocmé, Fallon, MacLaurin, et al., 2010). Although highly fragmented, Canada's child welfare system, like that of the United States is founded on the central principle that child welfare must put the child at the centre of all interventions, decision making and services (Jud, Jones and Mikton, 2015: 10; Brownell, 2015). Often referred to as a "child safety approach to children's welfare," Canada's approach requires the removal of the child from the home if a welfare agency identifies the child at risk (Brownell, 2015). Foster homes typically provide temporary, day-to-day care for children for the duration of the case investigation and resolution (Brownell, 2015). This contrasts to the "family welfare approach" adopted by Australia and several European countries which involves the provision of intensive home support to families in order to remove risks while the child remains in the custody of the family (Keilthy, Warters, Brenner and McHugh, 2017; Brownell, 2015; Commonwealth of Australia, 2009).

In Canada, the practice of birth alerts has garnered considerable debate among child welfare advocates, practitioners, legal professionals and professional child welfare organizations regarding their efficacy in ensuring the safety and well being of children. Typically issued by child welfare workers without a mother's knowledge, birth alerts flag expectant mothers whose newborn may be at risk for harm, often—but not always—resulting in the traumatic apprehension of a newborn immediately after birth. Research shows that the removal of a baby at birth for child protection reasons impacts attachment and bonding between the newborn and mother which can have detrimental short and long term consequences for the newborn (Community Care, 2012). At a much more general level, for parents, the removal of a child elicits a wide range of psychological and physiological feelings—depression, anxiety, stress, pain, grief and guilt—feelings often associated with the tragic loss of a child (Broadhurst and Mason, 2017). "However, allowing a baby to be discharged from hospital to a family who are unable to provide appropriate protection may result in irreparable harm to, or even the death of, the baby" (Community Care, 2012). The immediate and life-long implications of parental neglect and abuse on children are well documented in empirical studies showing the breadth of developmental issues—physical, emotional, cognitive, social and various forms of psychopathology—children are at risk of when exposed to ineffective parenting and/or child neglect (Conley, 2003/2004: 16).

This scan identifies and reviews literature examining the efficacy of birth alerts for purposes of child protection. The issue is of importance for two central reasons. First, decisions informed by birth alerts can have a life-long impact on the lives of both children and parents. Failure to adequately assess a caregiver's potential to parent runs the risk of harming the child by either removing the child prematurely from a family or by subjecting the child to continued harm if returned to the family (Conley, 2003/2004).

Second, compared to other developed countries, Canada has an exceptionally high rate of children in care (Brownell, Chartier, Au et al., 2015: ix) and a disproportionate number of Indigenous children in care (Statistics Canada, 2016a). Considered to be among Canada's most vulnerable population, children in care either have no parents or for a number of different reasons—abuse, family conflict, neglect or parental incompetence— are taken from their parents by the child welfare system or courts (Sherlock and Culbert, 2015). Children in care are often confronted with numerous challenges as they navigate Canada's child welfare system. According to Amelia Merhar, a former foster child and now a Ph.D. candidate at the University of Waterloo, "[t]here are children in Canada's child welfare system who can't count the number of homes they have been in…Kids always hear the phrase, 'the placement didn't work out'…You're already often coming from a family on social assistance or with addiction or abuse issues. Then you're just bounced around and never really told why and it perpetuates feelings of shame and worthlessness" (Treleaven, 2019). In many cases, children in care simply "age out of the system" and are left to fend for themselves with very few if any supports made available to them (Canadian Observatory on Homelessness, n.d.; Gaetz, 2014). According to child welfare advocates, most children in care are "resilient and determined to survive on their own. But while some find varying degrees of success, others fall down" (Sherlock and Culbert, 2015). For foster children, the transition from care to adulthood and independence is often challenging as "[t]hey [must] bear the scars of physical and emotional trauma, yet are [also] expected to function independently, usually with little social or financial support, once they reach age [of majority]" (Tweedle, 2005: 3). Research shows that youth ageing out of care are at increased risk of: dropping out of high-school, becoming a parent at a young age; poverty; becoming unemployed or underemployed; becoming involved in the criminal justice system; experiencing homelessness; mental health problems; and substance abuse (Tweedle, 2005: 3; Canadian Observatory on Homelessness, n.d.).

1.1 What is a birth alert?

In general, "[a] birth alert is a document that [child welfare] staff complete and forward to local hospitals when it is felt that there are significant child protection concerns and hospitals need to be alerted to this, and their need to contact the [child welfare authorities], if/when [the expectant mother] attends their hospital to give birth" (Berrouard, 2017: 50). Information contained in birth alerts varies across jurisdictions, however most birth alert documents include: "the client's information, what the child protection concerns are, the access plan following the delivery (i.e. can the baby room in with the mother, who can visit with the baby), any safety or security issues for staff, as well as information in regards to the discharge plan for the baby" (Berrouard, 2017: 51).

For purposes of consistency and clarity, Table 1 provides an overview of the practice of birth alerts in the province of Manitoba (before the practice was ended), highlighting key characteristics and practices.

Table 1: Birth alerts and practices in Manitoba

Birth Alert Characteristic	Practice
Definition	• "A birth alert is when a Child and Family Services (CFS) agency or the mandating CFS authority completes and faxes either an alert or birth alert form to the interprovincial desk (located under each authority). The birth alert can come from all over Manitoba."[2]
Content	• A typical alert will: state that an agency has serious concerns regarding a mother's ability to protect her child and if the mother has other children in care; state what action is required on locating the mother and request the agency be notified soon as possible when mother has given birth; [and] confirm that the agency may apprehend the child at birth."[1]
Categories	• "There are two categories of birth alerts: 1) if you are over the age of 18 and [are] considered high risk; and 2) if you are under the age of 18 and [are a] unmarried minor. • The difference [between the two] is unmarried minors must be advised of their rights and [allowed] to request services by the agency. The intent…is to make sure that minor parents are advised of their right to request services by an agency under [Manitoba's child welfare protection legislation]."[2]
Population	• "Birth alerts apply to expectant mothers considered by agencies to be **high risk** in relation to the care they will provide for their newborn infant. The practice in Manitoba is to issue alerts to track and locate these high-risk expectant mothers."[1] • "Once the expected mother registers with a hospital, immediately a notice is on her file for hospital staff. The CFS agency will then confirm the mother and will **possibly** apprehend child at birth. • Every individual case is unique in regards to the concerns and capabilities of the parent(s)."[2]
Assessing a parent's risk level	• "Child and family services agency workers and supervisors are expected to assess the level of risk to children throughout the case management process to determine the priority that should be given a case. This begins with the Safety Assessment at intake when presenting issues indicate that a child is at risk of suffering harm or injury and may be in immediate need of protection. Response-time and client-contact standards are based on [four levels of risk—high, medium, low and no risk] to children." • High Risk: A child is likely to be seriously harmed or injured, subjected to immediate and ongoing sexual abuse, or permanently disabled or dies if left in his or her present circumstances without protective intervention."[3]

	• "Medium Risk: A child is likely to suffer some degree of harm if he or she remains in the home. Intervention is warranted. However, there is no evidence that the child is at risk of imminent serious injury or death. • Low Risk: The home is safe for children. However, there are concerns about the potential for a child to be at risk if services are not provided to prevent the need for protective intervention. • No Risk: The home is safe for children and there are no indications of potential risk to a child."[3]
Role of CFS	• "[CFS] investigates if: [t]here is an open case on [the] mother and other children prior to birth; [t]here are any accusations against the mother involving CFS; [and there is a family] history (protection case) [of involvement in CFS]. • The agency is responsible for the apprehension of the newborn infant at the hospital in cases of birth alerts. • The agency determines the placement after the apprehension (kinship, shelter, foster home)."[2]
Role and responsibilities of hospitals	• "[N]ewborn infants [are kept] in the hospital until the agency has either lifted the birth alert or until apprehension. • [I]information in regards to birth alerts is privileged information, only accessible to hospital staff (social workers) and agency workers. • Information with the expecting parents will not be shared until the intervening agency makes first contact."[2]
Parents' rights	• "A parent has a right to care for their newborn infant (as long as there is no child protection concerns). It is the parents' right to participate in decisions affecting their newborn infant and have a say in their placement (this is when planning is important and when people/family should be identified to the worker for possible placement if an apprehension takes place). • Parents have the right to not sign any forms or documents before speaking with a lawyer. The parents have the right to consult with a lawyer before [they] make any decisions related to CFS and their child. CFS may still apprehend because of protection concerns. • All documents and checks that have been paid for by an agency is the agencies property and it will remain in the parents file. If parents require additional checks the cost will be covered by the parents."[2]
Disclosure of birth alert to expectant parent(s)	• "[An expectant] mother [is often not notified] if a birth alert has been placed upon her and her unborn infant until [CFS] makes contact with the expecting mother. • [CFS] is not obligated to inform the parent(s) of the alert; some mothers are notified only if they have children already in care."[2]

Sources:
[1] (Manitoba) Child and Family Services Standards Manual. (2009). *1.3.1 Child Protection*. Winnipeg, Manitoba: Government of Manitoba. Retrieved from: https://gov.mb.ca/fs/cfsmanual/1.3.1.html#B7
[2] First Nations Family Advocate Office. (2019). *Birth Alerts and Pre-Natal*. Winnipeg, Manitoba: First Nations Family Advocate Office. Retrieved from: https://firstnationsfamilyadvocate.com/wp-content/uploads/Birth-Alert-PowerPoint.pdf
[3] (Manitoba) Child and Family Services Standards Manual. (2009). *1.1.0 Introduction*. Winnipeg, Manitoba: Government of Manitoba. Retrieved from: https://gov.mb.ca/fs/cfsmanual/1.1.0.html#A8

In Manitoba, the First Nations Family Advocate Office would often become involved in cases triggered by a birth alert for expectant Indigenous mothers. Upon notification of a birth alert, the First Nations Family Advocate Office would send a team—consisting of the advocate or assistant advocate, grandmother, and a prenatal and postnatal support worker—to the hospital to provide support to the family and prevent the apprehension of the newborn (First Nations Family Advocate Office, 2019: n.p.). Each team member was tasked with a specific role and/or function:

- Advocate/Assistant Advocate—The Advocate [acts] as a liaison between the agency and mother to develop a plan so that the newborn can stay with [the] mother. The advocate provides supports to the mother and newborn to ensure that they are kept together. If apprehension [is unavoidable], the advocate works with the mother to identify family members to [take] care [of] the child. [The] advocate [also] work[s] with the mother regarding her case plan and develop[s] a plan with the mother and agency for reunification. It is the goal that the newborn is placed with a family instead of placements in shelter or foster homes.
- Grandmother—Provides emotional and spiritual support; offer[s] a song for the family; a prayer for the child and family; [and] gift[s] the family with a pair of moccasins and a feather.
- Prenatal and Postnatal Support Workers—If [the First Nations Family Advocate Office] is notif[ied] of a potential birth alert, the prenatal support workers work with the expectant mother to offer support and services on: traditional parenting workshop; sacred babies workshop; best care practices for prenatal and postnatal families; support for a holistic approach to wellbeing; the empower[ment] [of] families through cultural identity and connection to elders; and individualized family assistance, hospital, labor visits [and] making nutritious meals (First Nations Family Advocate Office, 2019: n.p.).

Upon delivery, the newborn is welcomed with a series of traditional Indigenous practices that include: washing the newborn with smudge water or cedar water; a naming ceremony which is of particular importance if the child is to be apprehended as the ceremony helps to maintain a strong between mom and her newborn; a request that the placenta be given to the mother for the official placenta ceremony; and a request to have

the belly button also given to the mother to place it in a medicine bag, signifying that the newborn will always return home, even if it is apprehended (First Nations Family Advocate Office, 2019: n.p.).

Between December 2017 and 2018, the First Nations Family Advocate Office—in partnership with Southeast Child and Family Services—responded to 26 cases triggered by birth alerts. In all cases, support was provided to the women through the birth and/or apprehension process; and birth apprehensions were prevented in four of the 26 cases (Southeast Child and Family Services Annual Report, 2019: 52).

1.2 Children in care in Canada

In 2019, there were an estimated 54,139 children in out-of-home care across Canada, representing approximately 0.75% of children, or a rate of 7.46 per 1,000 children (Saint-Girons et al., 2020). "Because child welfare services fall under the jurisdiction of provincial and territorial authorities each province has different legislation pertaining to child protection interventions, making it difficult to compare rates of children in out-of-home care across provinces" (Canadian Child Welfare Research Portal: Canadian Statistics, n.d.). Among the most significant differences between provinces are provincial mandates regarding "the age to which children are eligible for services, the length of time a child can receive out-of-home care and the definition of out-of-home care" (Canadian Child Welfare Research Portal: Canadian Statistics, n.d.).

Table 2 provides a snapshot of children and youth in out-of-home care according to province and territory.

Table 2: Children and Youth in Out-of-Home Care, Province/Territory

Province/Territory (Year)	Children in Care	Child Population		Rate per 1,000[2]
		Age	Total	
Alberta (2019)	7,757	0-17	970,452	7.99
British Columbia (2019)	6,263	0-18	926,072	6.76
Manitoba (2019)	10,258	0-17	308,969	33.20
New Brunswick (2019)	983[i]	0-18	144,301	6.81
Newfoundland and Labrador (2019)	985	0-15	76,450	12.88
Northwest Territories (2014)	229	0-18	11,343	20.19
Nova Scotia (2019)	995	0-18	176,458	5.64
Nunuvut (2019)	358	0-18	14,943	23.96
Ontario (2019)	12,385	0-17	2,765,376	4.48
Prince Edward Island (2018)	111	0-17	29,226	3.80
Quebec (2019)	9,174	0-17	1,584,856	5.79
Saskatchewan (2019)	4,546[i]	0-15	244,476	18.59
Yukon (2019)	95	0-18	8,517	11.15

Data source: Saint-Girons et al. (2020)
i Number adjusted to include estimate of children in care on-reserve.

A closer examination of Canada's foster care population reveals that Indigenous children are overrepresented in care relative to Canada's non-Indigenous population and the rate of Indigenous overrepresentation in foster care continues to grow each year as Indigenous children are brought into care of the welfare system at an increasing rate (Statistics Canada, 2016a).[1] According to the results of the 2016 Census, Indigenous children under the age of 15 represent only eight percent of Canada's total child population, but account for 52 percent of the total foster child population (Statistics Canada, 2016a). First Nations children aged 0-14 living on reserve represented 1.8% of the total population in 2016, but accounted for 16.7% of the total number of children in formal care in 2019 (Saint-Girons et al., 2020).

The percentage of Indigenous children in care varies across the provinces and territories, reaching 90% in Manitoba (Micklefield et al., 2018). The situation is exacerbated by the fact that, in many cases, once in foster care, Aboriginal children remain in care longer (often remaining in permanent care) and are less likely to be returned to their families compared to their non-Aboriginal counterparts (Office of the Child and Youth Advocate Alberta, 2016; McKenzie, Bennet, Kennedy, Balla and Lamirande, 2009: 11). Although there has been some success in placing Indigenous children within their own community with extended family, a family with shared ethno-cultural background or foster care that is connected to the family unit, the majority of Indigenous children continue to be placed in non-Indigenous care resources (McKenzie, Bennet, Kennedy, Balla and Lamirande, 2009: 11).

The staggering number of Indigenous children in care has been called a "growing crisis" (Truth and Reconciliation Commission of Canada, 2015a, 2015b; Ontario Human Rights Commission, 2018). According the Dr. Cindy Blackstock of the First Nations Child and Family Caring Society of Canada, "this overrepresentation has increased to the point that the number of First Nations children placed in state care today is three times that at the height of residential school operations" (Blackstock, 2007; National Collaborating Centre For Aboriginal Health, 2013; Ontario Human Rights Commission, 2018). Data suggests the overrepresentation of First Nations children in care is driven by child maltreatment cases involving neglect which is closely associated with "household/family structural factors and caregiver risk concerns like those identified in a large proportion of First Nations investigations; factors such as poverty, caregiver substance abuse, social isolation and domestic violence can impede caregiver's abilities to meet children's basic physical and psychosocial needs" (Vandna, Trocmé, Fallon et al., 2011: xix). On April 12, 2018, the Ontario Human Rights Commission (OHRC) released, Interrupted Childhoods: Over-Representation of Indigenous and Black Children in Ontario Child Welfare. The report outlines the findings of the OHRC's inquiry into the over-representation of Indigenous and Black children in Ontario's child welfare system. The OHRC's (2018: 2) inquiry found that the overrepresentation of Indigenous children in Canada's foster care

[1] The over-representation of Indigenous children occurs at every phase of child welfare intervention from reports, investigation, substantiation, entry into care and placement in permanent child welfare care (das McMurtry, 2015; Blackstock, 2007).

system can be attributed to a number of "complex and multi-faceted" issues stemming largely from the intergenerational effects of colonialism and associated child welfare practices.

1.3 Prevalence of Birth Alerts in Canada

Inconsistencies in official provincial policies and statistics related to birth alerts (Stueck, 2019a) make it difficult to estimate the proportion of children placed in care that can be attributed to apprehensions resulting from birth alerts. However, what data is available provides some insight to the extent to which birth alerts are being used and the population most affected by them.

British Columbia

Although official statistics regarding the use of birth alerts are unavailable, a joint report by British Columbia's Ministry of Children and Family Development (MCFD) and Representative for Children and Youth revealed that a disproportionate number of Indigenous infants were removed and entered care between 2013 and 2018 (Government of British Columbia, 2018; Stueck, 2019a).[2] Key findings of the report included the following:

> • [i]nfants under age one represented 20 percent of all children and youth between the ages of birth and 18-years-old who were placed in care either by removal or under a [voluntary care agreement (VCA)] in 2017/2018. [S]ubstantially more infants entered care by removal within 12 months of birth than by VCA during a five-year period (2,378 versus 287).[3]

[2] The joint report from British Columbia's (B.C.'s) Ministry and Representative for Children and Youth was "triggered by a 2018 B.C. Supreme Court ruling that found the ministry had not adequately considered less-disruptive measures when an Indigenous baby was removed three days after birth" (Stueck, 2019). Also, in 2007, B.C.'s Representative for Children and Youth along with the Office of the Provincial Health Officer released the results of their investigation of the health and well being of children in care in British Columbia. The results, which were published in a joint special report entitled, "Health And Well-Being Of Children In Care In British Columbia: Educational Experience And Outcomes," revealed "[t]he majority of children in care at any given time [were] Aboriginal…and [a] higher percentage of children in care [was] Aboriginal than [was]recorded by the Ministry of Children and Family Development. (Government of British Columbia, 2007: 13).

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

- Looking only at infants who were removed and entered care within 12 months of their birth, [figures show] a total of 2,378 infants in this category were removed between 2013/2014 and 2017/2018. Of these infants, a higher number were Indigenous than non-Indigenous. For example, in 2017/2018, 448 infants were removed at less than 12-months-old, and of those, 59 per cent were Indigenous.
- Consistent across all age categories (birth to seven days; eight to 30 days; 31 to 365 days), a higher number of Indigenous infants were removed and entered care within 12 onths of birth compared to their non-Indigenous peers. Of the total 188 infants removed at the time of birth up to seven days, 102 (54 percent) were Indigenous and 86 (46 percent) non-Indigenous. For both Indigenous and non-Indigenous infants, the most common reason for entering care through a removal was neglect. Among the subtypes of neglect, the most frequent reasons for entering care under a removal were when the parent was unable or unwilling to care for the infant (65 percent) and cases involving neglect by a parent that included physical harm (19 percent) (Government of British Columbia, 2018: 5-7).

In 2019, British Columbia's government announced that it would be discontinuing the use of birth alerts. The decision to reverse government policy on birth alerts was attributed to a number of factors that included: "pressure from mothers and advocates and recommendations from the National Inquiry into Missing an Murdered Indigenous Women and Girls [MMIWG] to stop such alerts" (Stueck, 2019a). In a press release announcing the ending of birth alerts, the government acknowledged the detrimental impact birth alerts have had, particularly on Indigenous women and children:

> "We know that birth alerts have been primarily issued for marginalized women and, disproportionately, Indigenous women. We acknowledge the trauma women experience when they become aware that a birth alert has been issued. We also heard calls to end this practice from Indigenous communities, organizations and the report from the National Inquiry into [MMIWG]. Moving to a voluntary approach of providing early supports and preventative services to expectant parents will help them plan and safely care for their babies. This change to practice allows for a more trusting, collaborative relationship with service providers right from the beginning, while empowering women, their families and their communities to work together to care for their children. This step is consistent with [the government's mandate] to provide better supports to keep Indigenous children at home and out of care. It responds directly to the recommendation from the National Inquiry into [MMIWG] to stop using birth alerts and reflects our commitment to implementing the United Nations Declaration on the Rights of Indigenous Peoples, and the Truth and Reconciliation Commission (TRC) of Canada's Calls to Action. As always, a child's safety and well-being is our first priority. Because we know that children thrive when they can live safely with family, connected to their culture and community, our every effort must be on

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other less disruptive measure is available or adequate to protect the infant" (Government of British Columbia, 2018: 4).

> strengthening families and keeping them whole" (Government of British Columbia, 2019).

In conjunction with its' decision to end the use of birth alerts, British Columbia increased funding of pre- and post-birth programs (Robertson, 2020). This included increased funding for: "substance-abuse programming that allows mothers to attend with their children; [the promotion] of breastfeeding; and training for parents whose own families had been traumatized by domestic abuse, residential schools and the Sixties Scoop" (Robertson, 2020).

The decision to end the use of birth alerts was hailed by members of Indigenous communities, particularly those outside British Columbia as a momentous decision that required the attention of the rest of the country (Pindera, 2019). According to the Chiefs of the Southern First Nations of Manitoba, "[w]hat B.C. [did] is a great example that the rest of the country needs to follow suit on…Our mothers and children need to be supported in keeping families together" (Pindear, 2019).

Manitoba

In 2018,[4] Manitoba had 10,328 children in care of which 90 percent were Indigenous; surpassing all provinces in terms of the number of children in care and per capita rate of child apprehensions (Bailey, 2020; Brohman, 2019; Pindera, 2019). Between 2017 and 2018, it is estimated that 558 birth alerts were issued. During this period, apprehensions of newborns following birth alerts occurred, on average, about once a day (Bailey, 2020). Rather than removing a newborn from the mother's care following birth at a hospital and then carrying out the required checks, child welfare agencies are encouraged to work in partnership with expectant mothers to ensure a safe home environment for the newborn before the child is born (Ridgen, 2019). However, critics of birth alerts argue that prebirth assessments often result in a "high-risk designation with little to no evidence" (Ridgen, 2019). Manitoba's use of birth alerts garnered greater scrutiny and increased calls for a review of policy following a number of high-profile apprehensions—including one that was streamed live on social media in January of 2019—as well as recommendations from the National Inquiry into MMIWG, and the announcement of British Columbia's government to stop the use of birth alerts (Bailey, 2020; Gibson and Thompson, 2020).

In a news release issued on January 31, 2020, the Government of Manitoba announced that as of April 1, 2020, Manitoba would no longer issue birth alerts for high-risk expectant mothers, citing a lack of evidence that birth alerts were effective in increasing the safety of children (Government of Manitoba, 2020; Gibson and Thompson, 2020). However, the deadline was later pushed back to July 1, 2020 due to the spread of the COVID-19 virus.

Manitoba's Families Minister also noted that birth alerts did not align with the

[4] As of March 1, 2018

government's "commitment to transform the child welfare system and connect families with community-based supports and services" (Bailey, 2020). According to the Minister, discontinuing the use of birth alerts is vital to efforts to rebuilding trust with high riskmothers and communities disproportionally affected by birth alerts while ensuring the safety of children at risk:

> …[t]o build a relationship with an at-risk mother and connect her with the programs and supports she needs, first we need to build trust…Birth alerts are having the opposite effect, discouraging moms and families from reaching out at a time when we most want to work with them…Our priority is to help keep families together and reduce the number of children in care…We are shifting our focus toward better supports for expectant mothers including early interventions, reunification and better planning. [However, the] end of birth alerts will not affect the child welfare system's ability to protect children who are at risk of neglect or abuse. All Manitobans, including health-care providers, [will] continue to have a legislated duty to report if they think a child is at risk (Government of Manitoba, 2020).

In support of the government's decision to end the use of birth alerts, Manitoba's child welfare standards were revised to "remove references to birth alerts and clearly state expectations for a stronger focus on building voluntary partnerships with parents to address their strengths and needs, which may include the creation of a safety plan, followed by referrals to existing community, cultural and health-care services as needed" (Government of Manitoba, 2020). The Minister also noted that the Manitoba government will continue to develop initiatives and programs that "help connect families with the supports they need" (Government of Manitoba, 2020). This includes, building on the successful efforts of front-line supports provided by public health nurses and family resources centres, and existing supports and programs highlighted by Table 3.

Table 3: Resources for expectant and new parents in Manitoba

Program	Description
Families First	A voluntary home-visiting program focused on healthy parenting and child development, based on a referral from a public health nurse.
Strengthening Families	A sister program to Families First, which is operated in 21 First Nation communities and funded by the federal government.
Restoring the Sacred Bond	A pilot project being led by the Southern First Nations Network of Care, which will connect up to 200 high risk expectant mothers with an Indigenous doula through Wiijii'idiwag Ikwewag, which will support her parenting through a traditional, cultural lens.
Granny's House	A one-year pilot project to provide 24-7 temporary, culturally safe respite care to families who are experiencing challenges.

Villa Rosa	Provides residential peri- and post-natal services.
InSight Mentor Program	A program that connects women with mentors in an evidence-based program to prevent fetal alcohol spectrum disorders, deal with underlying addictions issues and improve overall health and wellness.
Parenting Student Support Program	Works with students who have children or are pregnant and want to stay in or return to school.
Manito Ikwe Kagiikwe, or the Mothering Project	A] single-window program to support the health and wellness of women and their families.

Source: Government of Manitoba. (2020, January 31). *Manitoba to End Use of Birth Alerts*. [News Release]. Retrieved from: https://news.gov.mb.ca/news/index.html?item=46808

Although child welfare advocates and Indigenous leaders applauded Manitoba's decision to end the use of birth alerts, they are "cautiously optimistic the move will change how services are provided in the province" (Hobson, 2020). Child welfare advocates such as Daphne Penrose of the Manitoba Advocate for Children and Youth argue that although Manitoba's decision to end birth alerts is commendable, any real difference in outcomes will also require "good social" work: "[t]hings will change when workers are working with families differently and in a way that is really addressing what's going on with the family…There are times when some parents are unable to safely parent and then how do you activate those places? All of that work should be done beforehand" (Hobson, 2020).

Child welfare experts are also disputing claims by the Manitoba government that the elimination of birth alerts will not require additional funding and resources for the increased demand in supports by parents and families (Robertson, 2020). According to the Government of Manitoba, the "province would not need to fund programming to end the practice [because those] organizations are already out there; they're already doing this, so they're already funded in various ways…ending birth alerts does not require additional funding because resources already exist" (Robertson, 2020). Mary Ellen Turpel-Lafond—a former Saskatchewan judge who specializes in child welfare and law professor—argues otherwise by pointing to the decision of British Columbia to increase funding of pre- and post-birth programming in 2019 when the government announced its decision to end birth alerts (Robertson, 2020). According to Cheryl Casimer, an advocate for First Nations issues, although the specifics of British Columbia's new policy and programming need to be addressed, recognizing the need for pre-natal and postnatal supports and training is essential if apprehensions are to decrease (Robertson, 2020). Casimer notes, "[i]f you don't put the proper roots in place to help moms and families, it won't be a birth alert but it will be another situation right down the road where you're dealing with an apprehension" (Robertson, 2020).

Michael Redhead Champagne—Indigenous advocate and member of the Manitoba Child

Welfare Legislative Review Committee—expressed his concerns over the lack of details regarding how assessments of risks and parents are to be conducted under Manitoba's revised policy (Hobson, 2020; Funk and Brohman, 2020). Champagne noted:

> "I'm nervous that it seems so piecemeal. I feel like there are many things that need to happen concurrently if we're actually going to transform the system to improve outcomes…We're going to need to have a better understanding from the Ministry of Families about how risks are going to be determined, about how parents and parenting capacity will be assessed…We need more information from Manitoba Child and Family Services so that parents have a better understanding of what is considered a protection concern when a baby is born" (Hobson, 2020).

For families that have children in care as a result of apprehensions triggered by birth alerts, the decision, although "too late" may help others avoid having to experience the trauma and lasting impacts of a birth alert experience. According to one couple whose child remains in care as a result of an apprehension at birth, "the decision won't help their family but it may help another…[According to the mother it's], one step closer to righting the wrongs that have been done and for that I'm happy…Hopefully, this means families can stay together now…It is almost a slap to the face at this point, but it is a win nonetheless and I know it will help many others," added the father (Hobson, 2020).

Other Provinces

As mentioned at the onset of the LS, official data on the use of birth alerts by provincial and territorial governments across Canada is limited and often inconsistent. Alberta's Ministry of Children's Services has indicated that the province does not practice birth alerts and therefore it could not provide any data on the practice (Stueck, 2019b); however, unverified media reports indicate that birth alerts have in fact been issued in cases involving expectant mothers, the majority being Indigenous women (Hainsworth, 2019). More recent reports indicate that Alberta officially ended the practice in 2019 (Marelj & Vikander, 2021).

In a 2019 media report, a spokesperson for Ontario's Ministry of Children, Community and Social Services, indicated that although Ontario "[does not have a] policy in place [for] birth alerts… some Children's Aid Societies in Ontario have established protocols with local hospitals relating to birth alerts…Ensuring that parents' information was not shared without their consent through birth alerts [is the responsibility of the] individual Children's Aid Societies" (Stueck, 2019b; Berrouard, 2017). In 2020, the Ontario government issued a new policy directive that orders children's aid societies to cease the practice of issuing birth alerts as of October 15, 2020 (Ministry of Children, Community and Social Services, 2020).

In 2009, New Brunswick's Ombudsman and Child and Youth Advocate confirmed the use of a birth alert in case involving the death of a newborn child whose parents had repeated contact with New Brunswick's Department of Social Development (Richard, 2009: 1).

When it was discovered that the mother had given birth, the Royal Canadian Mounted Police brought criminal charges against both the mother and father for the murder of the newborn (Richard, 2009: 1). An investigation of the circumstances surrounding the death of the newborn revealed that a birth alert had been placed on the mother because she was considered to "be more likely than others to take actions which [would] put [her] unborn child at risk" (Richard, 2009: 3).

On June 28, 2019, the Children, Youth and Families Act (CYFA) was proclaimed, replacing New Brunswick's Children, Youth Care and Protection Act (Government of Newfoundland and Labrador, 2019: n.p.). The CYFA represents the "legislative authority for the delivery of services to children, youth and families under the following programs: Protective Intervention Program; In Care Program; Placement Resources for Children and Youth in Care; and Youth Services Program (Government of Newfoundland and Labrador, 2019: n.p.). Revisions to policies in the Protection and In Care Policy and Procedure Manual were also made to reflect changes to the province's child welfare legislation. Revisions to policies involving services to expectant parents included the application of "Expectant Parent Birth Alerts" in cases where children were deemed "high risk" for removal upon birth (Government of Newfoundland and Labrador, 2019: 3). For an overview of key requirements associated with the application of Expectant Parent Birth Alerts and risk assessment criteria, see *Appendix C — Select Services to Expectants Parents (Policy 1.4.1), Protection and In Care Policy and Procedure Manual, Newfoundland and Labrador, 2020.*

Data provided by Saskatchewan's Ministry of Social Services show that the province issued 588 alerts between 2015 and 2018 resulting in 153 newborns being apprehended for "their own safety" (Taylor, 2019). According to the Ministry, birth alerts are only used in "extreme cases" and the ultimate goal of any intervention is to keep the family united (Stueck, 2019b). The Ministry could not assess how many of the birth alerts that were issued involved Indigenous women because the province does not collect data related to ethnicity (Stueck, 2019b); however, many Indigenous leaders suggest that Indigenous women are the targets of the majority of birth alerts (Warick, 2020). Despite growing criticism of birth alert practices, in 2019, the Government of Saskatchewan announced that it would continue to use birth alerts until a full review of the province's birth alerts policy was completed (Stueck, 2019b). Since this announcement, the Government of Saskatchewan hosted a number of workshops and engagement sessions on the issue involving community partners, including at-risk expectant mothers and families who had been involved in the child welfare system. According to the executive director of Indigenous services with child and family programs in the province, these sessions helped to inform the decision to officially end the practice of birth alerts as of February 1, 2021 (Vescera, 2021). Indigenous leaders in the province applauded the decision, but noted that new services to support at-risk mothers must now be introduced (Vescera, 2021).

Saskatchewan was joined by Prince Edward Island as the most recent provinces to end the practice of birth alerts in 2021. For an updated overview of the status of birth alert policies and practices in each province/territory, see Appendix D.

2.0 Debate Surrounding the Practice of Birth Alerts

2.1 The Case for the Continued Use of Birth Alerts

Child welfare advocates such as Daphne Penrose of the Manitoba Advocate for Children and Youth, note that "[b]irth alerts began as a way for child welfare agencies to flag mothers who were considered a possible risk to their newborns…and in theory are supposed to be a way for social workers to make sure mothers are getting the support they need" (Hobson, 2020).

Berrouard's (2017) study exploring the attitudes and practices of child welfare workers towards new mothers who are involved with the child welfare system while receiving perinatal care, characterized birth alerts as a "necessary evil" (2017: 50-51). The study found that, although "there was a general sentiment that [birth alert documents] are problematic because they almost automatically set mothers up to be viewed negatively by hospital staff… all of the participants expressed feeling that birth alerts are needed in certain instances" (Berrouard, 2017: 51).

In 2018, Flaherty, Meiksans, McDougall and Arney published the results of their exploratory research study examining the "impact of a Child-At-Risk electronic medical record (eMR) alert information sharing system on the practice of staff within the Northern New South Wales Local Health District (NNSW LHD) and the perceived outcomes for women and children experiencing interpersonal violence, abuse or neglect" (2018: 6). The eMR alert information sharing system was, according to Flaherty, Meiksans, McDougall and Arney (2018), designed as an early intervention tool for practitioners in identification of at risk children and pregnant women and prevention of future harm by providing them with the necessary supports:

> …[d]esigned to identify at-risk children and pregnant women, together with their families, the Child-At-Risk eMR alert was introduced by NNSW LHD to indicate wellbeing concerns (e.g. exposure to domestic and family violence, substance abuse, unmanaged mental illness or neglect) to health clinicians. By being alerted to this information, it is expected that clinicians can then provide an enhanced level of care to the child/woman, including early intervention to prevent further harm. The Child-At-Risk eMR alert system requires that staff who report a wellbeing concern to the New South Wales (NSW) Health Child Wellbeing Unit or the NSW Child Protection Helpline also apply a Child-At- Risk alert to the eMR of the reported child/pregnant woman. Other clinicians accessing the client/patient's eMR would then see the Child-At-Risk alert and be encouraged to take appropriate action (Flaherty, Meiksans, McDougall and Arney, 2018: 6).

The results of the exploratory study revealed that "the NNSW LHD Child-At-Risk eMR alert system [was] having a positive impact on healthcare responses to victims of interpersonal violence, abuse and neglect"(Flaherty, Meiksans, McDougall and Arney, 2018: 43). Key findings of the study included the following:

- clinicians agreed the alert provided information that could enable a more comprehensive assessment of the child or at-risk pregnant woman (e.g. the alert provided important and easy-to-access clinical information, the alert allowed the clinician to see immediately the child/ woman's child protection status) and improved communication between agencies working with the family (e.g. improved information exchange and referrals to additional services).
- The eMR system [allowed for the cross-pollination of] information spanning community health settings and for that information to be accessible to acute care services such as emergency departments and maternity units. This feature was described as one of the purposes of the alert: to combine disparate pieces of information (e.g. concerns for wellbeing noted by a community health based service) and have that information accessed by clinicians in the acute care setting (e.g. emergency departments), 24 hours a day, 7 days a week.
- The use of the eMR alert system also appeared to have a positive impact on practice. Eighty-seven percent of participants reported that when they saw an alert on the eMR of a client, they actively assessed whether referrals to additional services were necessary, and 75 percent of participants shared information with other prescribed bodies. Sixty percent of participants also reported that when they saw an alert, they tried to actively resolve barriers to appointment attendance. Half of the participants believed that the alert allowed clinicians to see immediately the child protection status of a child or woman.
- A high proportion of system-users indicated they understood alert systems in general…With regard to improving the system, future training and engagement of clinicians with the system should focus on medical officers. In particular, medical officer training should be undertaken to ensure doctors are aware of the system and are using the system in their everyday interactions with families experiencing vulnerability.
- Consistent with existing research, participants in this study expressed that they felt somewhat or very confident discussing a range of issues with clients, including relationship issues, parenting behavior and child wellbeing. Participants [also] felt that they would benefit in their practice from increased professional development and ongoing support in how to engage with families with complex needs.
- Although participants stated they needed more knowledge of the support services available for victims, and to know how to refer to those services, the majority also said they felt very confident in discussing referrals with clients. [E]mploying a standardised process would reduce the likelihood that some clients would receive superior care to other clients based on the resources available at the hospital or other healthcare setting where the client presented.
- Most of the Australian state and territory health departments indicated that although their eMR systems had the capacity to host an alert system, this capability was not being deployed (Flaherty, Meiksans, McDougall and Arney, 2018: 7-9).

According to Flaherty, Meiksans, McDougall and Arney (2018: 6), "these findings show the potential of a practice change to improve responses to victims of interpersonal violence, abuse and neglect within large organizations employing thousands of staff."

2.2 The Case against the use of birth alerts

The use of birth alerts highlights a dilemma child welfare workers often confront on a daily basis—how do you balance the harm of removing a child with the risk of abuse or neglect that the child faces by remaining in the home (American Bar Association, 2020c). As identified at the onset of the LS, research shows that the removal of a baby at birth for child protection reasons can have detrimental short and long term impacts on the child, mother and broader family. However, allowing a baby to be discharged from hospital to a family unable to provide the necessary care and protection may result in "irreparable harm to, or even the death of, the baby" (Community Care, 2012). In Canada, the issue is complicated by the fact that Indigenous children are overrepresented in care relative to Canada's non-Indigenous population and that the rate of Indigenous children in care system at an increasing rate (Statistics Canada, 2016a).

A Practitioner's Perspective

For many child welfare advocates, there is a general apprehension towards the use of birth alerts. Table 4 provides a snapshot of prevailing opinions of child welfare advocates regarding the use of birth alerts.

Table 4: Birth alerts - a practitioner's perspective

"[T]here's the child protection piece of me that says for sure we need [birth alerts] when there's a solid, safety and child protection reason, but then another piece of me knows how staff will judge these and will judge families when an alert is sent out." *—Child Protection Worker (Berrouard, 2017: 51)*
"[I]f we've sent a birth alert, [hospital staff] have already decided how things are going to go down it seems, I don't think it's fair…they've already made judgments about the family and about what [Children's Aid Society] should be doing just based on the alert." *—Child Protection Worker (Berrouard, 2017: 51)*
"[W]ith the older moms I've worked with, things seem to go better, more smoothly. When things haven't gone well, the mothers were younger — 16, 17, even 19 or 20 — this happened especially if a birth alert had been sent out." *—Child Protection Worker (Berrouard, 2017: 54)*
"It's striking to me that people think it's still okay to send a birth alert to the hospital without informing a woman. So I'm aware that other pre-natal providers have actually gotten scolded by, like, social service agencies, child protection agencies, both Indigenous

and non-Indigenous, because they actually found out about a birth alert and told a woman that there was a birth alert, right? So to me, like, I don't understand how that could be conceptualized, right? Because it would seem to me that it would be very important to tell people, like, if there was that kind of legal intervention happening. Like, I don't think it's acceptable in Canadian health care systems to hold that kind of important information and not let people know."

—Dr. Janet Smylie, Family Physician (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019a: 364)

"[B]irth alerts leave expectant mothers in a constant state of stress and anxiety…When she's in that state, it generally affects the child. And then to go in and give birth and have the baby removed within four to six days, that trauma is life-altering for good."

—Patricia Dawn, Red Willow Womyn's Society (Migdal, 2019)

Birth Alerts Have Damaging Short and Long Term Effects on the Health and Development of the Newborn

Research examining the separation of newborns at birth finds that separations "disrupts bonding and can have serious consequences for…children, including increased aggression among children" (Wall-Wieler, Roos, Brownell et. al, 2018: 2; Kenny, Barrington and Green, 2015; McKegney, 2003). According to a study by Howard, Martin, Berlin and Brooks-Gunn (2011), "[m]aternal availability is particularly important within the first two years of life because of the infant's limited understanding of the reasons for maternal absence and the timing of her return. As a result, experiences of separation may be particularly salient. Even those as brief as a few hours in duration can result in distress" (2011: 2).

A review of research by the American Bar Association (2020b) examining the effects of removing children from their parents more generally found separations have detrimental effects on the short and long term health and development of children that include, but are not limited to: increased risks of developing heart disease, diabetes, and even certain forms of cancer (Eck, 2018); developmental regression, difficulty sleeping, depression, and acute stress (Goydarzi, 2018); increased risk of a child becoming a runaway and a victim of child sex trafficking (National Center for Missing & Exploited Children, 2017); increased risks of future disorders (McNutt, 2018); impaired brain function (Wan, 2018; Carnes, 2018); and emotional and psychological issues (Trivedi, 2019).

Research also indicates that the removal of a child from the family into foster care can also have profound impacts on a child's health and development (American Bar Association, 2020a). When compared to children who remained at home, children removed and place in care had higher rates of: delinquency and teen pregnancies (Doyle, 2007); involvement in the criminal justices system, particularly later in adulthood (Doyle, 2008); healthcare requirements (Doyle, 2013; Schneider, Baumrind, Pavao et al., 2009); behavioural problems (Lowenstein, 2018; Lawrence, Carlson and Egeland, 2006);

adverse adult outcomes (Ryan and Testa, 2005); impaired cognitive development (National Scientific Council on the Developing Child, 2012); emotional impairment (VanTieghem and Tottenham, 2018; Schuengel, Oosterman and Sterkenburg, 2009); poor educational outcomes (Brownell, Chartier, Au et al., 2015; Schneider, Baumrind, Pavao et al., 2009); poverty (Schneider, Baumrind, Pavao et al., 2009; Doyle, 2007); and reliance on public assistance in adulthood (Schneider, Baumrind, Pavao et al., 2009).

Birth Alerts Have Damaging Short and Long Term Effects on the Well-Being of the Mother

Research examining the separation of newborns at birth finds that the disruption between mother and child caused by a separation can lead to "increased mental health conditions and substance use in mothers" (Wall-Wieler, Roos, Brownell et al., 2018). In many cases the simple fear of having a birth alert issued is significant enough to impact a woman's health, particularly during pregnancy (Malebranche, 2019b). According to Dr. Mary Malebranche of the University of Calgary, "fears of having a birth alert issued… can deter at-risk women from accessing prenatal care or, for example, from seeking treatment for a substance use disorder while pregnant" (Malebranche, 2019b), a concern that has also been expressed by Indigenous leaders and child welfare advocates (Stueck, 2019b). In many cases, subsequent pregnancies are often flagged as high-risk despite evidence that a woman has overcome any issues that resulted in the issue of the initial birth alert (Malebranche, 2019b), or as in some cases, simply because of experiences unrelated to giving birth, as illustrated by the following scenario:

> …[b]ecause [Sharon] was in foster care as a teen, her health file was permanently flagged by a child welfare agency. [Sharon] didn't know this until she had her first child in her mid-20s…Sharon, whose daughter was a few hours old when a social worker came to her hospital room to ask if she felt overwhelmed and needed the agency to "help" by taking her newborn. Sharon had no mental illness or addictions and wasn't homeless—things that could be deemed high risk and worthy of being flagged by an agency. She said didn't need their help but CFS took her newborn for two weeks so they could be sure. They eventually gave the baby back but that critical bonding time was damaged. Sharon had three more children and CFS showed up at the hospital each time—when she was well into her 30s—all because she had been flagged by a birth alert (Ridgen, 2019).

According to Malebranche (2019b), "[i]n the context of Indigenous families, the practice contributes to ongoing cycles of inter-generational trauma as many women for whom birth alerts are issued were themselves apprehended at birth."

Birth Alerts Unfairly Target Marginalized Women and Disproportionately, Indigenous Women

Child welfare advocates suggest, although birth alerts began as a means to identifying high risk pregnancies in hopes of providing the mother with the required supports, birth alerts quickly "became a tool for apprehensions" (Hobson, 202) "primarily used for

marginalized women, especially Indigenous women (Hobson, 2020; Kelly and Boothby, 2019; Malebranche, 2019). Table 5 provides a sample of quotes from Indigenous women flagged with birth alerts.

Table 5: In their own words - experiences of Indigenous women with birth alerts

"I felt like my heart was ripped out and stepped on"
—Nelson, Dufresne and Bloch (2018)

"[I was told] Children's Aid Society will be sitting at the door and they will take your baby…It just put extreme stress on me…I knew there was nothing wrong with the baby, but it was just the anxiety, the stress of those final seconds...That whole birth was stressful. They had no right to threaten me or threaten to take my baby. As an Indigenous woman, I did not feel safe and my baby didn't feel safe."
—Arce (2019)

"It has been traumatic to witness the lack of empathy and compassion shown during the apprehension of my child and even during my first court appearance. I am thankful if my baby and I have brought some awareness to this situation that is happening"
— Butler and Canadian Press (2019)

"I'm still scared. I'm an Indigenous woman. I'm young. I'm a single mom. They might just come and show up at the hospital….I didn't want them to keep my file open any longer, because having to look over your shoulder all the time when you have to deal with CFS is kind of stressful every day…I didn't want my son getting taken, and my new baby."
— Brohman (2019)

"Walking down the hallway after [I] left, it was like a movie...How did this happen, where I give birth to this baby, and it's supposed to be a wonderful day in our lives. But then these people come and take that away. That's just inhumane to do that to her, to do that to myself, to do that to my family, to do that culturally...When I was going through it, I didn't understand the impact [the apprehension] had until a little while later… and just seeing how she's affected, because she just hates going into car seats."[5]
—Frew (2020)

"It was supposed to be a day of remembering how beautiful a birth was. It turned into the most traumatizing, heart-aching story."
—Taylor (2019)

Birth Alerts are a Continuation of Racist and Discriminatory Colonial Policies

Both the National Inquiry into MMIWG and the TRC of Canada called for major change regarding the practice of birth alerts in Canada.

In 2019, the National Inquiry into MMIWG released its "Calls for Justice" which included stopping the separation of Indigenous children from their mothers stemming from birth alerts which it deemed to be "racist and discriminatory and…a gross violation of the rights of the child, the mother, and the community" (National Inquiry into MMIWG, 2019a: 355). It is argued that the practice of birth alerts is a "re-imagined version of the 60's Scoop, the colonial practice wherein the government ripped Indigenous children away from their families and adopted them out to white foster parents in an attempt to kill their culture by severing all familial and community ties" (Arce, 2019). For many, "[t]he targeting of Indigenous women giving birth is…part of the systemic attempt of "taking the Indian out of the child" by severing their familial connections and thus isolating them from land, traditional knowledge and culture: Arce, 2019). According to findings of the National Inquiry into MMIWG (2019a: 255) "[t]he Canadian state has used child welfare laws and agencies as a tool to oppress, displace, disrupt, and destroy Indigenous families, communities, and Nations. It is a tool in the genocide of Indigenous Peoples."

In 2015, the TRC of Canada released its findings along with 94 "Calls to Action" regarding reconciliation between Canadians and Indigenous peoples which included the elimination of practices that remove Indigenous children from their families:

> Indigenous individuals have the rights to life, physical and mental integrity, liberty and security of person and…Indigenous people have the collective right to live in freedom, peace and security as distinct peoples and shall not be subjected to any act of genocide or any other act of violence, including forcibly removing children of the group to another group (TRC, 2015a: 271).

The TRC (2015a, 2015b) found that Canada's history of Indigenous child protection has not only been incorrect, but also culturally destructive to generations of Indigenous peoples (Lindstrom and Choate, 2016: 47; Blackstock, 2007). The Indian Act, Canada's Indian Residential Schools, forced sterilization, the Sixties Scoop, the millennium scoop and colonization have victimized generations of Inuit, Métis and First Nations children, as well as the lives of their descendents (Riggs, 2012: 60). Pain, rage and grief of unresolved trauma from these tragic events have left many Aboriginal adults unable to deal with the complex demands of parenting and family life, without the necessary experience or adequate preparation for its demands, a fact that is overlooked by Canada's child welfare system (Riggs, 2012: 60; Lindstrom and Chote, 2016: 47). In many cases, Indigenous parents are simply deemed as not "good enough" requiring the removal of children from their families (Lindstrom and Choate, 2016: 47).

In addition to the findings of the National Inquiry into MMIWG and TRC, in 2018, the OHRC confirmed that services provided under Canada's system of child welfare were racially biased against Indigenous peoples (OHRC, 2018; Choate, 2018: 5; McKay-Panos, 2018). Racial biases linked to child welfare have a spillover effect by influencing policy, decision making about placement in out-out of home care, and ultimately, contributing to the overrepresentation of Indigenous children in care (Choate, 2018: 5, 32; McKay-Panos,

2018, Drake, Jolley, Laner et. al., 2011). The OHRC traced chronic family concerns such as poverty, poor and unsafe housing, substance use, mental health issues and social isolation to decades of oppressive and discriminatory policies such as Canada's Indian Residential Schools and Sixties Scoop which led to the removal of children from their family structures (McKay-Panos, 2018). Many of the structural biases that contributed to the Indian Residential Schools and Sixties Scoop are still being incorporated, and to some extent enhanced with child welfare decision making tools (Choate, 2018: 33). The OHRC noted that child welfare authorities can misinterpret poverty or cultural differences as neglect, and therefore refer members of racialized populations, such as Indigenous peoples to child welfare more often (McKay-Panos, 2018).

Following British Columbia's decision to stop using the practice of birth alerts, the First Nations Leadership Council in British Columbia argued that although the removal of birth alerts are a good first start, "it does little to address systemic and institutional racism toward Indigenous families and children" (Migdal, 2019). What is needed according to the First Nations Leadership Council is "a cross-ministerial approach to ensuring that all measures are taken to keep newborn infants with their mothers and to ensure that the maternal-child bond is preserved and protected" (Migdal, 2019).

4.0 Research Methods

A scan of both peer-reviewed journals and grey literature was carried out involving a series of steps that included:

1) the identification of key words/search terms (*see Section 4.1 Keywords/Search Terms*);
2) the identification of relevant data sources (*see Section 4.2 Data Sources*);
3) the development of search strategies (*see Section 4.3 Search Strategy*);
4) an extensive and detailed search of peer reviewed and grey literature;
5) literature screening and data extraction; and
6) a synthesis of the literature (*see Section 5.0 Results/Synthesis of Literature Scan*).

4.1 Keywords/Search Terms

A list of keywords/search terms was developed by examining government documents and legislation and recent news articles for alternative words, subject headings and phrases. This included the following: birth alert; birth apprehensions; apprehended at birth; and taken into care at birth. Throughout the search process, keywords/search terms were added, deleted or modified as different terms were discovered to enhance the search strategy.

4.2 Data Sources

Two categories of data sources were selected for the LS: 1) peer-reviewed journals found in electronic databases; and 2) internet based grey literature. An extensive number of

electronic databases and grey literature were searched beginning on February 18, 2020 through February 21, 2020 to identify relevant literature, including descriptive qualitative and quantitative studies for review. Databases searched included: Applied Social Sciences Index and Abstracts (ASSIA); Education Resources Information Center (ERIC); JSTOR; ProQuest; PsychINFO (OVID); Scholar's Portal; Scopus; Social Services Abstracts; Social Work Abstracts; Sociological Abstracts; and Web of Science. For a brief description of each database, please see *Appendix A — Sources of Information (Peer* Reviewed). The LS was expanded to include web based grey literature which included: dissertations and theses; conference proceedings; government publications; white papers; and working papers. Various search engines, research portals, dissertations and theses depositories and institution specific websites were utilized for the identification and collection of relevant data. For a detailed list, please see *Appendix B — Sources of Information (Grey* Literature). An additional search of the grey literature was conducted in June 2021 to update statistics and add more recent policy information within the LS.

4.3 Search Strategy

Search strategies were developed to meet the specifications and search parameters of each unique database. Search strategies that were used to maximize the number of relevant records retrieved included:

1) keyword and or exact phrase searches in the title, abstract or subject heading of a reference;
2) using Boolean operators (AND, OR and NOT) for different combinations of search terms; and
3) if available, filters specific to the database were used to refine and/or limit search results, allowing for the retrieval of relevant documents. Due to the limited availability of relevant literature, filters were used sparingly throughout the search process to ensure that that no literature was overlook.

Search strategies were tested and refined after search results were reviewed. A hand search of reference lists was used to supplement searches. Citation searching is effective in the identification of new and current literature on a subject, resulting in a much more comprehensive search and literature review.

4.4 Literature Selection, Data Extraction and Synthesis

The title and abstracts of records retrieved from the databases and grey literature were screened for key words and any duplicates removed. The absence of variables of interest (e.g. keywords) relevant to the research objective were used as exclusion criteria. Pertinent information was extracted from the literature and presented in tabular form (*see Section 5.0 Results/Synthesis of Literature Scan*). The extracted data included: the studies' author(s) and year of publication; the source of literature (i.e. peer-reviewed or grey literature); country of study; study objectives; and a synthesis of results/findings.

5.0 Results/Synthesis of Literature Scan

Tables 6 through 13 present the studies identified by the LS along with the extracted data and synthesis of findings. The results of the scan reveal limited evidence based research assessing the efficacy of birth alerts. Although the characterization of birth alerts as "problematic" and growing disapproval of birth alerts were common themes, supporting literature has largely been exploratory and untested. Recent decisions by several provinces to discontinue the use of birth alerts highlight the growing discontent with the practice; however, provide insufficient evidence to accurately assess the efficacy of birth alerts. This void was echoed by the Government of Saskatchewan when it announced that any decisions to modify or discontinue the province's birth alert practices following its review of policy would require sound scientific evidence and viable alternatives. Reviews of Canada's child welfare policies by the 2019 National Inquiry into MMIWG and 2015 TRC of Canada, as well as the 2018 OHRC review of welfare practices in Ontario provide strong arguments for the re-evaluation and/or removal of existing child welfare practices, such as birth alerts that unjustly target Indigenous women and families. Studies by Flaherty, Meiksans, McDougall and Arney (2018) and Berrouard (2017) are effective in illustrating the often diverging and profound impacts alerts can have on different populations and their utility as tools in child welfare. Much more rigorous and peer reviewed studies modeled on those of Flaherty, Meiksans, McDougall and Arney (2018) and Berrouard (2017) are necessary in order to build a solid foundation of evidence based research that can be used by policy makers and practitioners to assess the efficacy of birth alerts.

6.0 Conclusions

The results of the LS revealed a limited body of evidence based research assessing the efficacy of birth alerts. The majority of existing literature is exploratory in nature, requiring rigorous and systematic testing before any results can be used for guidance and decision-making. The profound effects birth alerts can have on the health and well being of children and families—particularly those of marginalized populations such as Canada's Indigenous peoples—demands greater cooperation and coordination between policymakers, practitioners and researchers, all of whom play a central role in supporting evidence-informed policy making.

Table 6: Literature synthesis – Funk & Brohman (2020)

Variable	Description
Author(s)/Date	Funk and Brohman (2020, January 30)
Literature Source (Peer Reviewed/Grey)	Grey Literature (News Article)
Article Headline	Review Finds No Evidence Birth Alerts Improve Child Safety, Manitoba Families Minister Says
Country	Canada
Central Argument(s)	• "Manitoba's families minister has told a Winnipeg-based news network a controversial practice that can lead to newborns being taken away from their mothers doesn't appear to be working to actually protect the children." • "We conducted a review of the birth alert process, and what we found is that there's no evidence to prove that this ... increases the safety of children in any way," Families Minister Heather Stefanson said in an interview with APTN News, which aired Thursday on the network. Birth alerts are warnings from social services agencies to a hospitals, intended to flag the history of a mother who is considered "high-risk." The alerts may lead to a baby being apprehended from its mother in the hospital. We heard very loud and clear … through our legislative review committee, as well as through the MMIWG inquiry, who both recommended the end of the practice of birth alerts," Stefanson told APTN News." • "[Birth alerts are] extremely damaging to the overall well-being of the mother and the children, and the entire family that's connected," Michael Redhead Champagne, a member of the Manitoba Child Welfare Legislative Review Committee, told CBC News Thursday. Champagne explained that in many First Nations communities, the birth of a child is a significant celebration for the entire community. When a birth alert comes in and interrupts that connection between mother and child, and that family and the entire community, we're not allowed to fulfil our responsibilities as First Nations people to welcome that life into this world in a good way," he said. Birth alerts, he added, have potential lifelong impacts on both the mother and child. There is a lack of trust among many Indigenous people toward the child welfare system, Champagne said, which the alerts compound. They also cause people to lose trust in the health-care system."

Table 7: Literature synthesis – Arce (2019)

Variable	Description
Author(s)/Date	Arce (2019, June 25)
Literature Source (Peer Reviewed/Grey)	Grey Literature (Newspaper Article)
Article Headline	Analysis: 'Birth Alerts' Are Colonial Tools Meant To Dehumanize And Decimate Indigenous Resistance. MMIWG Final Report Calls For Immediate End to the Barbaric Practice
Country	Canada
Central Argument(s)	• "One of [the] leading "calls of justice" [proposed by the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG)] was to stop separating Indigenous children from their mothers through so-called "birth alerts" – the practice of tipping off children's social services and police when women considered "high risk" give birth. Ostensibly, this means that it's done only in "extreme circumstances" out of concern for the safety of both mother and child…But the reality is that across Canada, hospital staff have routinely taken it upon themselves to call children social service agencies and police departments, often on trumped up accusations of being drunk, drugged or unfit to care for the child." • "In fact, it's a re-imagined version of the 60's Scoop, the colonial practice wherein the government ripped Indigenous children away from their families and adopted them out to white foster parents in an attempt to kill their culture by severing all familial and community ties." • "The targeting of Indigenous women giving birth is, of course, part of the systemic attempt of "taking the Indian out of the child" by severing their familial connections and thus isolating them from land, traditional knowledge and culture. This, the MMIWG Report clearly states, is nothing other than genocide. It thus outlines multiple "Calls for Justice" which include the "immediate end to the practice of targeting and apprehending infants...from Indigenous mothers." According to the document, Canada "has a legal obligation to fully implement these Calls for Justice."

Table 8: Literature synthesis – Fursetenau (2019)

Variable	Description
Author(s)/Date	Fursetenau (2019, September 16)
Literature Source (Peer Reviewed/Grey)	Grey Literature (Newspaper Article)
Article Headline	Birth Alerts Discontinued In BC
Country	Canada
Central Argument(s)	• "Removing birth alerts from accepted practice within MCFD is an important step to ensuring families stay together for the well-being of all family members involved," said Sonia Furstenau, MLA for Cowichan Valley and B.C. Green spokesperson for Children and Family Development. "But this change is long overdue. • "Birth alerts have long been recognized as damaging and violent. They target women and infants at the most vulnerable and critical moment of their lives. The evidence is overwhelming: when we separate moms and babies, we are creating long-term problems for both of them. The best way to support infants is to support families by ensuring parents-to-be receive prenatal services and preventive care. • "Increasingly, Indigenous and First Nations communities are asserting their inherent rights and jurisdiction over their children. This government needs to recognize this, and end its colonial practices."

Table 9: Literature synthesis - National Inquiry into Missing and Murdered Indigenous Women and Girls, Volume 1A (2019a, 2019b)

Variable	Description
Author(s)/Date	National Inquiry into Missing and Murdered Indigenous Women and Girls, Volume 1A (2019a)
Literature Source (Peer Reviewed/Grey)	Grey Literature (Government)
Country	Canada
Findings	• "[R]emoval of a child from its parents at birth represents one of the very worst forms of violence; and that, once removed, it can be exceedingly difficult to get a baby back. One of the most egregious and ongoing examples of violence against mothers and against children is the operation of birth alert or newborn apprehension systems" (p. 364). • "While there are, at times, legitimate reasons for child apprehension at birth regarding child safety, evidence suggests that the birth alert system disproportionately impacts Indigenous women and their infants" (p. 364). • "Birth alerts are one of the contributing factors to the disproportionate rates of the apprehension of Indigenous infants and children by child welfare" (p. 364). • "One aspect of the birth alert practice that Indigenous health care and child welfare advocates find particularly troubling is that they continue to target and punish Indigenous women across their childbearing experiences where these alerts may apply to women who have had other children in care – even if the time elapsed is over a decade long" (p. 365) • "[O]ngoing targeting of Indigenous mothers and newborns in this way effectively erases the possibility that Indigenous women can create the relationships and care necessary for children, especially if they have been prevented from doing so in the past through forced separation." — Dr. Janet Smylie, Cree/Métis(p. 365) • "[B]irth alerts, and the subsequent separation between mother and baby…when the newborn is apprehended, hold significant negative impacts for both mother and baby…if we just looked at mental health outcomes and health outcomes over the lifespan, that is definitely critically interfering with the development of the child. And that doesn't account for the health and mental health of the mother. So, to me, having a child apprehended in that manner would be comparable to the death of a child, both on the family and the mother." — Dr. Janet Smylie, Cree/Métis (p. 366)

Table 9: Literature synthesis - National Inquiry into Missing and Murdered Indigenous Women and Girls, Volume 1A (2019a, 2019b)

Variable	Description
Findings (continued)	• "While practices such as birth alerts, as well as the medical evacuation of pregnant women from remote communities to give birth elsewhere, are often justified as a means of mitigating risk…this particular definition of risk is limited and reflective of a colonial, biomedical understanding. As she argues, this way of understanding risk in relation to birth and parenting" (p. 367). • "[T]he birth alert system and infant apprehensions actually lead Indigenous expectant mothers to avoid going to a hospital or reaching out for medical support out of fear that their child will be apprehended" (p. 367).
Conclusions	• "The use of birth alerts against Indigenous mothers, including mothers who were in care themselves, can be the sole basis for the apprehension of their newborn children. Birth alerts are racist and discriminatory and are a gross violation of the rights of the child, the mother, and the community" (p. 355). • "Ensuring the health and well-being of Indigenous mothers and their newborns is an important part of rebuilding Indigenous families and communities in ways that also lessen the potential for further violence and harm" (p. 368). • "[T]his involves examin[ing] the legality of birth alerts and the practice of birth alerts and newborn apprehension." — Cora Morgan, Sagkeeng First Nation • "[T]his begins with valuing and protecting these early relationships...This includes…embracing practices that can generate health, well-being and strength. This also includes, as the evidence demonstrates, supporting practices like community midwifery and the right to give birth at home and within the community, to ensure that the bonds of safety that are created in that moment are cemented for life, and can ultimately contribute to safety later on" (p. 368). • "We call upon provincial and territorial governments and child welfare services for an immediate end to the practice of targeting and apprehending infants (hospital alerts or birth alerts) from Indigenous mothers right after they give birth" (p. 195).*

*Source: National Inquiry into Missing and Murdered Indigenous Women and Girls (Canada). (2019b). *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls. Volume 1B*. Ottawa: National Inquiry into Missing and Murdered Indigenous Women and Girls. Retrieved from: https://www.mmiwg-ffada.ca/wp content/ uploads/2019/06/Final_Report_Vol_1b.pdf

Table 10: Literature synthesis - Flaherty, Meiksans, McDougall and Arney (2018)

Variable	Description
Author(s)/Date	Flaherty, Meiksans, McDougall and Arney (2018)
Literature Source (Peer Reviewed/Grey)	Grey Literature (Research Report)
Country	Australia (New South Wales)
Study Objective(s)	• "This project sought to understand the impact of a Child-At-Risk electronic medical record (eMR) alert information sharing system on the practice of staff within the Northern New South Wales Local Health District (NNSW LHD) and the perceived outcomes for women and children experiencing interpersonal violence, abuse or neglect" (p. 6). • "Designed to identify at-risk children and pregnant women, together with their families, the Child-At-Risk eMR alert was introduced by NNSW LHD to indicate wellbeing concerns (e.g. exposure to domestic and family violence, substance abuse, unmanaged mental illness or neglect) to health clinicians. By being alerted to this information, it is expected that clinicians can then provide an enhanced level of care to the child/woman, including early intervention to prevent further harm" (p. 6). • "The Child-At-Risk eMR alert system requires that staff who report a wellbeing concern to the New South Wales (NSW) Health Child Wellbeing Unit or the NSW Child Protection Helpline also apply a Child-At-Risk alert to the eMR of the reported child/pregnant woman. Other clinicians accessing the client/patient's eMR would then see the Child-At-Risk alert and be encouraged to take appropriate action" (p. 6).
Findings	• "High levels of knowledge about and agreement that the use of the Child-At-Risk eMR alert system improves practice were found across surveyed staff" (p.9). • "The use of the Child-At-Risk eMR alert system also appeared to have a positive impact on practice" (p. 8).

Table 10: Literature synthesis - Flaherty, Meiksans, McDougall and Arney (2018)

Variable	Description
Findings (continued)	• "Half of the participants believed that the alert allowed clinicians to see immediately the child protection status of a child or woman. Forty percent agreed that it provided important and easy-to-access clinical information, and 24 percent agreed that it facilitated improved communication with other service providers. Overall, far more participants (36.5%) felt that the Child-At-Risk eMR alert helps families, than those participants (only one, less than 1%) who felt that the alert did not help families. Thirty-three percent of participants indicated that they did not know if the alert system helped families, with the remainder not responding. This indicates that either those practitioners may not know the outcomes for children and their families, or that the practitioners see the alert more as a benefit to their own practice than for families. Around one-third (37.6%) of participants also felt that children and at-risk pregnant women are safer now that the system is in place. Two participants (1%) reported that there had been a negative outcome due to the presence of the alert on the client's eMR, suggesting that the experience of negative client outcomes from the alerts had been small. These two participants did not state what the negative outcomes were" (p. 8). • "A high proportion of system-users indicated they understood alert systems in general" (p. 8). • "With further regard to improving the system, future training and engagement of clinicians with the system should focus on medical officers" (p.8). • "Consistent with existing research, participants in this study expressed that they felt somewhat or very confident discussing a range of issues with clients, including relationship issues (80.3%), parenting behaviour (88.2%) and child wellbeing (80.9%). Participants in both groups felt that they would benefit in their practice from increased professional development and ongoing support in how to engage with families with complex needs" (p. 8). • "Although over half (56%) of Group 1 (staff who had applied a Child-At-Risk alert to a client eMR) participants stated they needed more knowledge of the support services available for victims, and to know how to refer to those services, 61 percent also said they felt very confident in discussing referrals with clients" (p. 8).

Table 10: Literature synthesis - Flaherty, Meiksans, McDougall and Arney (2018)

Variable	Description
Findings (continued)	• "No clear differences were observed between participants located in major cities, inner regional or outer regional locations on responses to the alerts or perceived client outcomes, although this may be due to small group sizes in location groups. This was expected, and supports the notion that employing a standardized process would reduce the likelihood that some clients would receive superior care to other clients based on the resources available at the hospital or other healthcare setting where the client presented" (p. 8). • "Most of the Australian state and territory health departments indicated that although their eMR systems had the capacity to host an alert system, this capability was not being deployed" (p. 8).
Conclusions	• "The project confirmed that many staff within the NNSW LHD are identifying and responding to victims of interpersonal violence, abuse and neglect in their day-to-day work and that the Child-At-Risk alert supplements, rather than replaces, usual care approaches. An important finding of this study was that approximately one-third of the participants reported that the presence of the alert resulted in the adaptation of their practice. In addition, these adaptations to practice were made despite constraints on time and resources. These findings show the potential of a practice change to improve responses to victims of interpersonal violence, abuse and neglect within large organisations employing thousands of staff" (p. 6). • "Examination of the Child-At-Risk alert system operating in NNSW LHD shows that clinicians agreed the alert provided information that could enable a more comprehensive assessment of the child or at-risk pregnant woman (e.g. the alert provided important and easy-to-access clinical information, the alert allowed the clinician to see immediately the child/woman's child protection status) and improved communication between agencies working with the family (e.g. improved information exchange and referrals to additional services)" (p. 7). • "This result shows the potential power of the eMR system to cross-pollinate information spanning community health settings and for that information to be accessible to acute care services such as emergency departments and maternity units. This feature was described as one of the purposes of the alert: to combine disparate pieces of information (e.g. concerns for wellbeing noted by a community health based service) and have that information accessed by clinicians in the acute care setting (e.g. emergency departments), 24 hours a day, 7 days a week" (p. 7).

Table 10: Literature synthesis - Flaherty, Meiksans, McDougall and Arney (2018)

Variable	Description
Conclusions (continued)	Implications for Policy and Practice • "Given the positive results on healthcare responses to victims of interpersonal violence, abuse and neglect highlighted by this exploratory study on the NNSW LHD Child-At-Risk eMR alert system, the system may have the potential to be adopted more widely within Australia and internationally. Also, the research findings have identified a number of key implications for policy and practice that can support improved health worker responses to clients and patients experiencing or at risk of experiencing violence, abuse or neglect nationally" (p. 9). • "Research using case-file data is needed to determine direct client/patient-level outcomes from the presence of a Child-At-Risk eMR alert" (p. 9). • "Alert systems should be implemented using established procedures and regular staff training" (p. 9). • "Features of the system should meet end-user needs" (p. 9). • "Tracking staff-users should result in a greater understanding of the system's use" (p. 9). • "Health workers need ongoing training and information on responding to interpersonal violence, abuse and neglect" (p. 10). • "Standardised alert systems could be implemented across states and territories" (p. 10).

Table 11: Literature synthesis – Ontario Human Rights Commission (2018)

Variable	Description
Author(s)/Date	Ontario Human Rights Commission, 2018
Literature Source (Peer Reviewed/Grey)	Grey (Government Document)
Country	Canada (Ontario)
Study Objective(s)	• "For decades, Indigenous, Black and other racialized families and communities have raised the alarm that their children are over-represented in the child welfare system. Although Indigenous and racialized children's pathways through the system are quite different, Ontario-based research shows that racial disparities—that is, differences between racial groups at decision-making points in a service—do exist. The number of Indigenous children in care is staggering, and the Truth and Reconciliation Commission of Canada (TRC) has called the situation a "growing crisis." • The issues that give rise to the over-representation of Indigenous and Black children in the child welfare system are complex and multi-faceted. For example, low income, which is one of the inter-generational effects of colonialism, slavery and racism in society, is a major driver of child welfare involvement for Indigenous and Black children. Many Indigenous, Black and other racialized families, communities, advocates and others are also concerned that systemic racial discrimination in the child welfare system plays a significant role. • To respond to these concerns, in 2016 the Ontario Human Rights Commission (OHRC) launched a public interest inquiry to examine the involvement of Indigenous and racialized children and youth in the child welfare system. We used our powers under s. 31 of the Ontario Human Rights Code to request information from children's aid societies (CASs) on their race-based data collection practices and how they track children and families receiving their services. • The goal was to examine whether Indigenous and Black children are over-represented at CASs, particularly in admissions into care. We were concerned because racial disproportionality (the over- or under-representation of certain racial groups in a service relative to their proportion in the general population) and racial disparity may be indicators of systemic racial discrimination. This report discusses the results of this analysis, and describes the human rights-based data collection practices CASs use" (n.p.).

Table 11: Literature synthesis – Ontario Human Rights Commission (2018)

Variable	Description

Findings	• "Despite the limitations of the race-based data the OHRC received from mainstream CASs, the OHRC observed disproportionately high incidences of Indigenous and Black children in admissions into care at many of these agencies across the province. Although the racial disproportionality data presented in this report is not conclusive of discrimination by CASs, it is a starting point for CASs and the government to look critically at racial inequality in the sector.
	• When considered along with the long-standing issues people in Indigenous and Black communities have raised about discrimination in the child welfare sector, the disproportionalities we found raise serious concerns for CASs. CASs should act on these findings by investigating whether their structures, policies, processes, decision-making practices and organizational cultures may adversely affect Indigenous and Black families, and potentially violate the Ontario Human Rights Code.
	• Key findings of the OHRC include the following:]
	  ○ Indigenous children were over-represented in admissions into care at 93 [percent] of agencies looked at (25 of 27), with many CASs showing extreme levels of disproportionality. Overall, the proportion of Indigenous children admitted into care was 2.6 times higher than their proportion in the child population. These figures likely underestimate the proportions of Indigenous children admitted into care, in part because the OHRC's sample only included non-Indigenous (mainstream) CASs.
	  ○ Black children were over-represented in admissions into care at 30 [percent] of agencies (8 of 27). Overall, the proportion of Black children admitted into care was 2.2 times higher than their proportion in the child population.
	  ○ In contrast, at more than half of the 27 CASs, White children were under-represented among children admitted into care (15 of 27 agencies or 56 [percent]).
	  ○ Race-based data collection processes and practices are a patchwork across the sector. [The OHRC] looked at 38 mainstream CASs' data collection practices. These CASs' human rights-based (particularly race-based) data collection practices are widely inconsistent with each other and vary even within many individual agencies.

Table 11: Literature synthesis – Ontario Human Rights Commission (2018)

Variable	Description
Findings (continued)	Key Findings • More than 40[percent] of CASs did not know the racial backgrounds or Indigenous identities of more than one in five children served by their agency, when considering referrals, cases opened for investigation, and admissions of children into care. Four agencies did not know the racial backgrounds or Indigenous identities of over half the children placed into care. • For most CASs, these gaps and inconsistencies make it statistically difficult to assess if racial disparities exist across different service decisions (such as placing children into care), which makes it difficult to assess whether systemic racial discrimination may be happening."
Conclusions	• "The Ontario Human Rights Code aims to create "a climate of understanding and mutual respect for the dignity and worth of each person so that each person feels a part of the community and able to contribute fully to the development and well-being of the community and the Province." Whether because of systemic discrimination in the child welfare system or broader social exclusion, the over-representation of Black and Indigenous children in admissions into care stands in the way of achieving this vision of society. Being admitted into care comes with far-reaching consequences that can have a negative impact on children's future ability to thrive. • Identifying and addressing potential systemic racial discrimination in the child welfare sector is one part of the picture. The broader social and economic issues that contribute to the over-representation of Indigenous and Black children in child welfare also need to be addressed. These issues require a multi-pronged response from government, CASs and civil society to create truly equitable outcomes for Indigenous and racialized children and families" (n.p.).

Table 12: Literature synthesis – Berrouard (2017)

Variable	Description
Author(s)/Date	Berrouard (2017)
Literature Source (Peer Reviewed/Grey)	Grey (Dissertation)
Country	Canada (Ontario)
Study Objective(s)	• "[E]xplores the stigmatization that new mothers who are involved with the child welfare system experience while receiving perinatal care at the Brantford General Hospital. It seeks to consider how these two very powerful systems mutually influence one another, and in what manner the relationship between these organizations impacts the experiences of new mothers receiving perinatal care at this particular hospital"(p. 1).
Findings	• "Through interviews with four child welfare workers, it was found that mothers involved in child protection are heavily stigmatized when accessing perinatal care at the Brantford General Hospital. This was reflected in the participants' narratives about mothers they have worked with experiencing increased exclusion and surveillance, and more hurried and judgemental care within this hospital setting; these stigmatizing experiences are amplified when mothers are young and/or indigenous" (p. 59). • "[A] clear theme that emerged from the interviews was participants' concern around Brant [Family and Children's services] FACS' birth alert document. • A birth alert is a document that [Children's Aid Society] CAS staff complete and forward to local hospitals when it is felt that there are significant child protection concerns and hospitals need to be alerted to this, and their need to contact the Society, if/when this mother attends their hospital to give birth. In general, the birth alert documents outline the client's information, what the child protection concerns are, the access plan following the delivery (i.e. can the baby room in with the mother, who can visit with the baby), any safety or security issues for staff, as well as information in regards to the discharge plan for the baby" (pp. 50-51). • While all of the participants expressed feeling that birth alerts are needed in certain instances, there was a general sentiment that these documents are problematic because they almost automatically set mothers up to be viewed negatively by hospital staff"(p. 51).

Table 12: Literature synthesis – Berrouard (2017)

Variable	Description
Findings (continued)	• "A major concern that participants raised was in regard to the use of the birth alert document as a source of stigma and surveillance. As it is currently exists, the birth alert document used by Brant FACS is quite structured and forensic in nature. It is also centred primarily around risk factors, and how these will be managed if necessary. There is no clear opportunity for CAS staff to outline the strengths and positive factors in regard to expectant mothers they are working with. The predominate focus on risk and safety measures in the current document sets clients up to be viewed, almost automatically and inevitably, as being "risky" or "bad" (p. 63). • "[Participants] expressed feeling that the birth alert documents, by virtue of the language used and the information asked for, are "very judgemental and forensic" (p. 51). • "The majority of the participants expressed feeling that the issues outlined above were compounded when the mothers they were working with were young and/or indigenous. It is significant to note, however, that only the participants working on Brant FACS' First Nations First Response team identified indigenous identify as being stigmatizing for mothers within this hospital; there was no recognition of this significant intersection by participants who do not work with this population. This signifies a potential (and concerning) lack of awareness or consideration on the part of some staff at Brant FACS around how race functions as a complex intersection in the lives and experiences of certain women the agency serves" (p. 52).
Conclusions	• "The narratives expose significant concerns with Brant FACS' birth alert document and how this is interpreted and applied by hospital staff. This document is essentially a textual representation of surveillance between Brant FACS and the Brantford General Hospital. While all of the participants expressed feeling that birth alerts are necessary in certain instances, this document is problematic in the sense that it routinely sets mothers up to be regarded, automatically and often lastingly, by hospital staff as purely "a collection of risk factors to be managed" (Brown, 2006, p. 355). This document gives hospital staff permission to monitor and regulate certain women more harshly, and this has serious implications in terms of the care and interactions that mothers receiving perinatal treatment at this hospital experience. What is further concerning is that, as revealed in the narratives, the negative implications of this document are oftentimes already at play before a women has even been admitted to this hospital to deliver her baby' (p. 51).

Table 12: Literature synthesis – Berrouard (2017)

Variable	Description
Conclusions (continued)	• "More collaboration and consideration on the part of Brant FACS staff when completing birth alerts, the comprehensive modification of Brant FACS' birth alert document altogether potentially, and improved coordinated care between Brant FACS and the Brantford General Hospital are just a few intended points of intervention that arose from this study. The fundamental goal of this project (and any future related research that may be conducted) is that it serves to improve the care and birth experiences of women impacted by the complex, overwhelming and oftentimes very stigmatizing mechanisms that function within and between Brant FACS and the Brantford General Hospital, and that are amplified when these systems operate in certain women's lives simultaneously" (p. 77). Implications for Policy and Practice: • "While birth alerts are necessary in certain instances, the existing document - the information it asks for, how it is received and likely judged by hospital staff - seems to result in the convergence of the stigmatizing surveillance and assessment practices inherent to both the child welfare and healthcare systems. This document appears to almost generate, amplify and justify the "multiple modes of surveillance" that marginalized women often face in their interactions with different health and social service agencies" (p. 69; Greene et al., 2015: p. 232) • "On this basis, Brant FACS' birth alert document would be a good starting point in terms of beginning to address some of the stigma – and ensuing exclusionary, judgemental and scrutinizing treatment – that mothers involved with both Brant FACS and the Brantford General Hospital appear to experience fairly routinely. Although individual values and beliefs will likely always influence how birth alerts are completed by Brant FACS staff, and how they are subsequently received and interpreted by hospital staff, there are nonetheless changes that could be made that could lessen its potentially stigmatizing impact for our mutual clients" (p. 69).

Table 12: Literature synthesis – Berrouard (2017)

Variable	Description
Conclusions (continued)	• "One study participant recommended that training be offered to staff specifically around completing birth alerts – when and why they are needed (i.e. not simply as a "heads up" to the hospital, but rather, when there are solid, serious child protection concerns). When feasible and appropriate, the birth alert documentation could be completed openly with clients, so as to allow for better transparency and collaboration, and where possible, the inclusion of the clients' own voice and plan. The document could be made less forensic in nature. This could be accomplished, arguably and importantly, via the inclusion of a section that solicits information in regards to strengths, protective factors and/or positive features that a client possesses or demonstrates, or that exist within the family. Including such a section would not only better align with Brant FACS' espoused values of an antioppressive and strengths-based approach to working with families, but could potentially work against the routinely negative judgement of service users that the current document produces. Allowing for space to speak to strengths, and when possible including clients in the completion of the birth alert documentation, could perhaps also work to combat the paradox of increased monitoring alongside less consideration and acknowledgement of service users' needs and experiential knowledge that occurs so often for stigmatized individuals in the context of social and human service involvement" (pp. 69-70).

Table 13: Literature synthesis – Truth and Reconciliation Commission of Canada (2015a, 2015b, 2015c)

Variable	Description
Author(s)/Date	Truth and Reconciliation Commission of Canada, 2015a, 2015b, 2015c
Literature Source (Peer Reviewed/Grey)	Grey (Government document)
Country	Canada
Study Objective(s)	• "The Truth and Reconciliation Commission of Canada (TRC) was established in 2008 under the terms of the Indian Residential Schools Settlement Agreement. The Commission was mandated to: reveal to Canadians the complex truth about the history and the ongoing legacy of the church-run residential schools, in a manner that fully documents the individual and collective harms perpetrated against Aboriginal peoples, and honours the resilience and courage of former students, their families, and communities; and guide and inspire a process of truth and healing, leading toward reconciliation within Aboriginal families, and between Aboriginal peoples and non-Aboriginal communities, churches, governments, and Canadians generally. • The process was to work to renew relationships on a basis of inclusion, mutual understanding, and respect. More specifically, the Commission was required to hold seven National Events; to gather documents and statements about residential schools and their legacy; to fund truth and reconciliation events at the community level; to recommend commemoration initiatives to the federal government for funding; to set up a research centre that will permanently house the Commission's records and documents, which the parties were obligated to provide to the Commission, thereby establishing a living legacy of the Commission's work; and to issue a report with recommendations" (2015b: 23).

Table 13: Literature synthesis – Truth and Reconciliation Commiss ion of Canada (2015a, 2015b, 2015c)

Variable	Description
Findings	• "For over a century, the central goals of Canada's Aboriginal policy were to eliminate Aboriginal governments; ignore Aboriginal rights; terminate the Treaties; and, through a process of assimilation, cause Aboriginal peoples to cease to exist as distinct legal, social, cultural, religious, and racial entities in Canada. The establishment and operation of residential schools were a central element of this policy, which can best be described as "cultural genocide" (2015c: 5). • "Canada separated children from their parents, sending them to residential schools. This was done not to educate them, but primarily to break their link to their culture and identity" (2015c: 5-6) [and] "part of a coherent policy to eliminate Aboriginal people as distinct peoples and to assimilate them into the Canadian mainstream against their will" (2015c: 6). • "In order to redress the legacy of residential schools and advance the process of Canadian reconciliation, the [TRC] makes the following calls to action [concerning Canada's system of child welfare]: 1) We call upon the federal, provincial, territorial, and Aboriginal governments to commit to reducing the number of Aboriginal children in care by: i. Monitoring and assessing neglect investigations. ii. Providing adequate resources to enable Aboriginal communities and child-welfare organizations to keep Aboriginal families together where it is safe to do so, and to keep children in culturally appropriate environments, regardless of where they reside. iii. Ensuring that social workers and others who conduct child-welfare investigations are properly educated and trained about the history and impacts of residential schools. iv. Ensuring that social workers and others who conduct child-welfare investigations are properly educated and trained about the potential for Aboriginal communities and families to provide more appropriate solutions to family healing. v. Requiring that all child-welfare decision makers consider the impact of the residential school experience on children and their caregivers" (2015b: 319).

Table 13: Literature synthesis – Truth and Reconciliation Commission of Canada (2015a, 2015b, 2015c)

Variable	Description
Findings (Continued)	• In order to redress the legacy of residential schools and advance the process of Canadian reconciliation, the [TRC] makes the following calls to action [concerning Canada's system of child welfare]: 2) We call upon the federal government, in collaboration with the provinces and territories, to prepare and publish annual reports on the number of Aboriginal children (First Nations, Inuit, and Métis) who are in care, compared with non-Aboriginal children, as well as the reasons for apprehension, the total spending on preventive and care services by child-welfare agencies, and the effectiveness of various interventions. 3) We call upon all levels of government to fully implement Jordan's Principle. 4) We call upon the federal government to enact Aboriginal child-welfare legislation that establishes national standards for Aboriginal child apprehension and custody cases and includes principles that: i. Affirm the right of Aboriginal governments to establish and maintain their own child-welfare agencies. ii. Require all child-welfare agencies and courts to take the residential school legacy into account in their decision making. iii. Establish, as an important priority, a requirement that placements of Aboriginal children into temporary and permanent care be culturally appropriate. 5) We call upon the federal, provincial, territorial, and Aboriginal governments to develop culturally appropriate parenting programs for Aboriginal families" (2015b: 319-320).
Conclusions	• Indigenous individuals have the rights to life, physical and mental integrity, liberty and security of person and…Indigenous people have the collective right to live in freedom, peace and security as distinct peoples and shall not be subjected to any act of genocide or any other act of violence, including forcibly removing children of the group to another group" (2015a: 271). • "The Truth and Reconciliation Commission of Canada believes that in order for Canada to flourish in the twenty-first century, reconciliation between Aboriginal and non-Aboriginal Canada must be based on the following principles.

Table 13: Literature synthesis – Truth and Reconciliation Commission of Canada (2015a, 2015b, 2015c)

Variable	Description
Conclusions (Continued)	1) The United Nations Declaration on the Rights of Indigenous Peoples is the framework for reconciliation at all levels and across all sectors of Canadian society. 2) First Nations, Inuit, and Métis peoples, as the original peoples of this country and as self-determining peoples, have Treaty, constitutional, and human rights that must be recognized and respected" (2015c: 3). 3) Reconciliation is a process of healing of relationships that requires public truth sharing, apology, and commemoration that acknowledge and redress past harms. 4) Reconciliation requires constructive action on addressing the ongoing legacies of colonialism that have had destructive impacts on Aboriginal peoples' education, cultures and languages, health, child welfare, the administration of justice, and economic opportunities and prosperity. 5) Reconciliation must create a more equitable and inclusive society by closing the gaps in social, health, and economic outcomes that exist between Aboriginal and non-Aboriginal Canadians. 6) All Canadians, as Treaty peoples, share responsibility for establishing and maintaining mutually respectful relationships. 7) The perspectives and understandings of Aboriginal Elders and Traditional Knowledge Keepers of the ethics, concepts, and practices of reconciliation are vital to long-term reconciliation. 8) Supporting Aboriginal peoples' cultural revitalization and integrating Indigenous knowledge systems, oral histories, laws, protocols, and connections to the land into the reconciliation process are essential. 9) Reconciliation requires political will, joint leadership, trust building, accountability, and transparency, as well as a substantial investment of resources. 10)Reconciliation requires sustained public education and dialogue, including youth engagement, about the history and legacy of residential schools, Treaties, and Aboriginal rights, as well as the historical and contemporary contributions of Aboriginal peoples to Canadian society" (2015c: 3-4).

Appendix A – Sources of Information (Peer Reviewed)

Databases	Description
Applied Social Sciences Index & Abstracts (ASSIA)	Designed to serve the information needs of the caring professions, including practitioners, researchers, and students in healthcare, social services, education, and related areas. It is focused on a core of around 500 of the most relevant English language scholarly journals covering aspects of health and social care from a broadly social scientific perspective. Subject coverage includes: education; family; gerontology; health services; housing; mental health services; nursing; socia l work; and substance abuse.
Education Resources Information Center (ERIC)	Online library of education research and information, sponsored by the Institute of Education Sciences of the U.S. Department of Education
JSTOR	Electronic database of interdisciplinary peer reviewed journals.
ProQuest	Multidisciplinary search engine of academic journals, newspapers, e-books, and more.
PsychINFO (OVID)	Contains citation information and abstracts from journals in psychology and mental health. The Ovid platform is appropriate for systematic and scoping reviews as well as other advanced searches.
Scholars Portal	Collection of e-journals, e-books, social science and geospatial data.
Social Services Abstracts	Citations and abstracts of academic journals, dissertations, and book reviews.
Social Work Abstracts	Bibliographic information and abstracts of scholarly journals dating from 1977 to the present.
Sociological Abstracts	Citations and abstracts of scholarly journals, dissertations, books, and conference papers in the social and behavioural sciences.
Scopus	Multidisciplinary bibliographic and citation database with extensive journal coverage especially in science, technology and medicine and is expanding its coverage of the social sciences Web of Science Citation information and research impact factors.
Web of Science	Citation information and research impact factors for multidisciplinary journal articles, conference papers, and books.

Appendix B – Sources of Information (Grey Literature)

Databases	Description
Search Engines	• Google (https://www.google.ca/advanced_search) • Google Scholar (https://scholar.google.com/intl/en/scholar/about.html) • Bielefeld Academic Search Engine (https://www.base-search.net/)
Research Portals	• ResearchGate (https://www.researchgate.net/) • King's College (London) Research Portal (https://kclpure.kcl.ac.uk) • Social Science Research Network (SSRN) (https://www.ssrn.com/index.cfm/en/) • OpenAIRE (https://explore.openaire.eu/) • Semantic Scholar (https://www.semanticscholar.org/)
Theses	• Center for Research Libraries Foreign Dissertation (https://www.crl.edu/collections/topics/dissertation) • Digital Access to Research Theses Europe (DART) (http://www.dart-europe.eu) • Open Access Dissertations (https://oatd.org) • Thesis Canada Portal (http://www.bac-lac.gc.ca/Pages/default.aspx) • Electronic Theses Online Service (ETHOS) (https://ethos.bl.uk) • ProQuest Dissertations and Theses (https://www.proquest.com/products-services/pqdtglobal.html)
Institution Specific	• Various
Other	• OpenGrey (http://www.opengrey.eu/)

Appendix C – Select Services to Expectants Parents (Policy 1.4.1), Protection and In Care Policy and Procedure Manual, Newfoundland and Labrador, 2020 [1]

Provision[2]	Requirement
Policy	• The Department of Children, Seniors and Social Development (DCSSD) does not have legislative authority under the CYFA to intervene in child protection matters involving unborn children; however, the DCSSD may work with an expectant parent(s) who **voluntarily** agrees to involvement with the DCSSD and whose unborn child is determined at **high risk for removal upon birth.** • Where an expectant parent(s) whose unborn child is determined at high risk for removal upon birth declines services from the DCSSD a social worker shall, in consultation with a supervisor, develop an intervention plan to assess the child's safety upon birth. • A social worker shall initiate a protection investigation in accordance with Structured Decision Making (SDM)® Manual following the birth of a child determined at high risk for removal upon birth. • Where information is received regarding the behavior of an expectant parent(s) that indicates a child protection investigation is required upon the child's birth, a social worker shall promptly notify the local hospital(s) using the **Expectant Parent Birth Alert** to Hospitals form and continue to provide updated information to the hospital as needed to plan for the child's birth (pp. 1-2)
Engaging Parents	• Where information is received regarding an expectant parent(s) and a social worker has determined the child is at high risk for removal, the social worker shall contact the expectant parent(s) and: a) explain that the DCSSD has received information indicating a potential concern for the child's safety, upon birth; b) explain the DCSSD's mandate (to ensure the safety and wellbeing of children in need of protection) with the expectant parent(s) and discuss their interest in working voluntarily with the DCSSD on the identified concerns prior to birth of the child. • The expectant parent(s) **will not be contacted** in situations where a social worker has information to suggest that contact in advance of the child's birth may result in risk of parental self-harm or a risk of the expectant parent fleeing the region or province to avoid child protection intervention. (pp. 3-4)

Notes: [1] Current as of February 19, 2020.
[2] This is not a comprehensive list of provisions. Please consult the Manual for detailed provisions and associated revisions to policy.
Source: Government of Newfoundland and Labrador. (2020). *Protection and In Care Policy and Procedure Manual*. Government of Newfoundland and Labrador.

Provision	Requirement
Determining High Risk for Removal	• A social worker's determination of a child's risk for removal upon birth will be based on information received from the reporter and information contained in child protection records. There may be times when a social worker may need to contact the expectant parent(s) to determine the child's risk for removal. Collaterals working with the expectant(s) parent may also be contacted but only with the expectant parent(s) written consent. • A social worker shall consider the following factors to determine whether a child is at high risk for removal upon birth: a) Current or previous child protection involvement with the expectant parent(s), including maltreatment concerns reported and outcome of investigations, safety threats, risk factors, risk rating on previous Risk Assessments and the parent's response to child protection intervention; b) Whether the expectant parent(s) had or currently has a child in the care/custody of a manager, or living in an out of home arrangement; c) Whether the expectant parent(s) is suspected of or is participating in drug/alcohol activities that would seriously impair their ability to meet the child's basic and developmental needs; d) If the expectant parent(s) has a mental health concern/illness or cognitive impairment that would present a threat to the child's safety; e) If the expectant parent(s) is participating in community services (e.g. pre-natal services, addictions services); and the success of those interventions; f) Availability of formal and informal supports to the expectant parent(s) and child upon birth; (p. 3) g) If the expectant parent(s) is living in a situation where there is violence that would present a threat to the child's safety; h) Whether information currently known about the expectant parent(s) would be screened in for an investigation and prioritized as a same day response if the child was born today; i) Any other information a social worker believes is important to determining a child's risk for removal upon birth (p.3).

Provision	Requirement
Role of DCSSD as Service Provider	• When an expectant parent voluntarily agrees to work with the DCSSD, the DCSSD will engage with the expectant parent to ensure they are connected with community programs and services. Early engagement provides the opportunity for social workers to plan with expectant parent(s), in advance of the child's birth, to determine the safest plan for the child upon birth (i.e. discharged from the hospital to the parent's care, a family member/significant other's care, or in care of a manager) and enhance positive outcomes for children and families. • Where an expectant parent(s) has agreed to work voluntarily with the DCSSD, supports and services that may be provided include having discussions with the expectant parent(s) on how they may begin to address the identified concerns by working with community service partners such as public health, mental health, addictions or others. The social worker may make referrals to other agencies on behalf of the expectant parent(s) but only with the expectant parent's written consent. Collaboration with informal and formal supports may also occur but only with the expectant parent's written consent. As well, the social worker may plan with the hospital to prepare for the child's removal, if a removal is required. Lastly, the social worker may prepare court documentation in advance, if a removal is required and the social worker has the required information (p. 4).
Information on children determined not at high risk for removal upon birth	• Where a decision is made that follow up is required with a seven day response following the child's birth, the social worker shall notify the local hospital by completing and sending an **Expectant Parent Birth Alert** to Hospitals form and advising the hospital to notify the DCSSD pending the child's birth. (p. 5)

Provision	Requirement
Alerting Hospitals	• Alerts will be sent to hospitals for an expectant parent(s) whose child is determined at high risk for removal or expectant parent(s) whose child is not at high risk for removal but will require investigation upon birth. A social worker, in consultation with a supervisor, shall use their professional judgment to determine if an expectant parent who is engaged in voluntary services will be notified of the alert in advance of the child's birth. • Where a decision is made that follow up is required with a seven day response following the child's birth, the social worker shall notify the local hospital by completing and sending an **Expectant Parent Birth Alert** to Hospitals form and advising the hospital to notify the DCSSD pending the child's birth (pp. 5-6).
Expectant Parent Declines Child Protection Services	• Where an expectant parent whose child is deemed at high risk for removal declines to work voluntarily with the DCSSD, a social worker shall, in consultation with a supervisor, plan for the child's birth by: a) Reviewing child protection records; b) Preparing court documentation in advance; c) Posting an alert, including directions for DCSSD at response, in the On Call System; d) Sending an alert to other zones/provinces if the parent is transient or there is a risk of flight to avoid child protection intervention; and, e) Sharing updated information and collaborating with hospital staff to plan for an assessment of the child's safety/potential removal upon birth (p. 6).

Appendix D – Current Status of Birth Alerts by Province/Territory

Province/ Territory	Status	Information on Prevalence
Alberta	Ended 2019	No statistics available
British Columbia	Ended September 16, 2019	At least 444 birth alerts were issued between Jan 1, 2018 and Aug. 31, 2019. Over half (58%) of birth alerts in 2018 affected Indigenous parents.[1] 28% of birth alerts resulted in apprehension of infants.[2]
Manitoba	Ended July 1, 2020	281 birth alerts were issued from Apr-Dec 2019, compared to about 500 alerts annually in previous years.[3]
New Brunswick	Still in place (currently under review)	No statistics available
Newfoundland and Labrador	Still in place (currently under review)	No statistics available
Northwest Territories	Not in place for over a decade	No statistics available
Nova Scotia	Still in place (currently under review)	No statistics available
Nunavut	Unknown	No statistics available
Ontario	Ended October 15, 2020	Birth alerts are not tracked; however, it has been reported that 442 children aged 7 days-12 months were removed from their mother between July 2019-July 2020, with 50% of referrals coming from medical staff.[4]
Prince Edward Island	Ended February 1, 2021	About 1-15 birth alerts are issued each year. 6 out of 63 alerts in the last 5 years resulted in infants being removed from their families.[5]
Quebec	Still in place	Provincial statistics not available. In the Abitibi-Témiscamingue region (western Quebec), 18 out of 54 birth alerts in 2019 and 17 out of 54 birth alerts in 2020 were for Indigenous babies.[6]
Saskatchewan	Ended February 1, 2021	76 birth alerts were issued in 2020 (lower than the average from the previous four years of 152), of which 53 affected Indigenous mothers.[7] The majority of children 30 days or younger who were taken into care between 2015 and 2019 (341 out of 439) were Indigenous).[8]
Yukon	Ended May 2019	Birth alerts have not led to a child being taken into care since 2017.[9]

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