Victimized or Validated?

Responses to Substance-Using Pregnant Women

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Les femmes qui utilisent des substances nocives durant leur grossesse sont souvent stigmatisées et jugées par le discours public, On a l'impression que c'est la santé et les droits du foetus qui sont primordiaux, et non la santé de la femme. Les auteures préconisent une politique et un traitement qui valident à la fois la santé de la mère et de l'enfant

Substance use among pregnant women is a major public health problem in Canada. Some studies estimate that approximately 20-30 per cent of pregnant women in Canada and the United States use tobacco (Coleman and Joyce; Connor and McIntyre), with one study estimating tobacco use as low as eleven per cent (Health Canada 2002). Data suggest that the rate of smoking during pregnancy varies greatly with the age of the woman. In a 1998-1999 survey of mothers with children under two years of age, 53 per cent of mothers under 20 years of age had smoked during pregnancy, compared to 12 per cent of mothers aged 35 years or older (Health Canada 2003).

Approximately ten per cent (9.6 per cent) of Canadian women who were pregnant at the time of the 2001 Canadian Community Health Survey indicated they drank alcohol *during the past week* (compared to 44.5 per cent of women who were not pregnant). Over 14 per cent of mothers indicated that they drank alcohol *during their last pregnancy.* These are likely underestimates, as surveys may miss accessing women facing serious health, economic, housing, and other social problems. In addition, the significant societal stigma regarding pregnant women's use of alcohol, drugs, and tobacco may also prevent some women from identifying use of any of these substances, even in the context of a survey.

Pregnant women who use substances come under considerable scrutiny in Canadian society. Analyses of public discourses regarding pregnant women as users of alcohol, drugs, and tobacco have revealed judgmental, blaming, and unsympathetic attitudes and practices (Greaves *et al.* 2002; Rutman *et al.* 125). The focus of legal, media, and public concern is usually on the health and welfare of the fetus and rarely on the health and welfare of the woman herself. This article examines the impact of perspectives that consider substance-using pregnant women primarily as "vessels" for producing children, and how such approaches fail to validate women's lives, health, and experiences, while ignoring structural circumstances that affect them. We argue that when a broader approach is taken, programs and policies can be developed that reflect a concern about women, mothers, *and* children, and promote better health and well-being for all.

Seeing substance-using pregnant women primarily as "vessels" often leads to seeing them as entirely responsible for their situation and any potential damage to their fetus. In recent years this perspective has been evident across sectors: in legal cases, policies, media headlines, and treatment approaches. This perspective reflects a set of attitudes and practices that often puts substance-using pregnant women second, and sometimes casts their rights in conflict with those of the fetus or child. It also affects the way programs have been developed to intervene with women and how policies have been used to respond to these issues.

In existing policy and law, the rights of mothers with substance use problems have been frequently set in competition with those of their fetuses/children. This is seen in child welfare policy, in drug policy, and in all-too-frequent media "cases" where mothers are publicly punished for using substances during pregnancy. For example, child welfare policy may refer to children's needs as "paramount" and use evidence of *any* alcohol or drug use to prevent mothers from retaining custody. In drug policy, Susan Boyd argues that "medical social and legal professionals consider persecuting mothers as 'saving' the fetus and the newborn from the risk of both the mother and the drugs they have consumed" (93). Unfortu-

nately, and not surprisingly, this "competing rights" approach itself can become a barrier to women, resulting in substance-using pregnant women being afraid or reluctant to seek treatment partly out of fear of prejudicial treatment and eventual child apprehension (Poole and Isaac).

The tensions around this issue became very publicly evident in the key legal debate examined by the Supreme Court of Canada in the "Ms. G" case in 1997, which focused on the case of a woman from Winnipeg who was using solvents during pregnancy. In the Ms. G case, the pivotal point being tested was whether or not the state could apprehend Ms. G and impose mandatory treatment on her, out of concern for her fetus. This case focused Canadian attention on the apparent conflict: in a case of potential harm due to substance use during pregnancy, whose rights should prevail? The answer, as far as the media were concerned, was that "unborn children" needed protection from "abusive" mothers (Rutman *et al.* 51). Such a view is a punitive approach akin to an American "war on drugs" policy, because substance use by mothers was rarely explored or contextualized. In the media, substance use (whether of a legal substance like tobacco or alcohol, or an illegal drug) is often presented as an individual, deliberate choice that causes harm to fetuses and children.

In a study examining the content of Canadian news articles on substance-using pregnant women and mothers, we found headlines such as "Judge orders woman not to get pregnant for 10 years: Drugs affected child" and "Save the Children" (Pearson). This latter headline topped a review of a book that argues for understanding the context of the lives of women who use substances, and their capacities as mothers, but media articles rarely considered the social determinants of women's health (Greaves *et al.* 2002). Closely related was the lack of consideration for health and social interventions that might support women's improved health, and in turn, their capabilities as mothers.

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Similar issues arise in policy application. When an agency committed to protecting child welfare assesses "risk" for the fetus or infant, measures are often used that reflect the interests of the fetus or child solely, and assess that risk in isolation from the welfare of the woman or mother, or from the perspective of the family system. For example, the *Risk Assessment Model for Child Protection* (BC Ministry for Children and Families) in BC which complements the *Child, Family and Community Service Act* (Province of British Columbia) has strongly worded risk criteria, suggesting that even occasional substance use (level two) can have serious negative effects on parents' behaviour such as "job absenteeism, constant arguments at home, dangerous driving" and "short-term stupor" impairing parental "childcare performance." These risk criteria can lead to dramatic results for parents including separation of a substance-using mother and child due to apprehension, fostering, or adoption. Sometimes life-long separation is the result, causing unmeasured impact on the long-term emotional health of both the child and woman.

The implications of a fetus-centred approach in all these arenas are significant and troubling to advocates of women's empowerment and equality. As Nancy D. Campbell argues, "beneath the legitimate and compelling concern for 'drug-addicted babies' lies a basic animosity to women's self-governance" (918). Many Canadians were affected by the Ms. G. case because it raised key questions about women's autonomy and bodily integrity, mandatory treatment and the comparative "rights" of mothers, women, and the fetus. However, key elements were missing from the public discourse in this case, such as a full discussion of the barriers to care for substance-using women, acknowledgment of the lack of visible, comprehensive, and welcoming treatment services, and exploration of the link between the substance use and the conditions and experiences in women's lives.

FASD and Tobacco Use

Although Ms. G's solvent use was a particularly dramatic case, in part because of the degree of her addiction and the public's judgement of solvent use as "scandalous," the judgements about her also resonate in discussions of tobacco and alcohol use by pregnant women, which are both more common practices. Alcohol and tobacco are the most commonly used drugs by women and have the most severe implications for fetal development. Through examining the dominant responses to two issues of substance use during pregnancy—Fetal Alcohol Spectrum Disorder (FASD) and smoking during pregnancy—we can identify and assess new approaches that could be more effective and validating of women.

FASD refers to a range of birth defects and developmental disabilities resulting from exposure to alcohol during pregnancy. While its diagnostic criteria continue to be refined and debated, it has gained acceptance in North America as a key condition resulting from heavy drinking while pregnant. FASD has pri-

marily been regarded as an expensive health problem that is entirely preventable through individual behaviour change, with little attention and compassion paid to the difficult lives of women who have addiction and related trauma, mental health, poverty, or other issues. Janet Lynne Golden has documented how women who used substances during pregnancy were initially portrayed sympathetically in the American media as having health problems, but how this discourse changed under the leadership of government officials and legal professionals—so that FASD came to be understood as a "*social* deformity that expressed the moral failings of mothers and marked their children as politically marginal and potentially dangerous" (2).

In Canada, a dominant response to FASD has been the creation of public messages about the dangers of drinking during pregnancy, and a focus on diagnosis and intervention with those affected. Motivations for reducing the incidence of FASD are often framed in terms of preventing more births of affected children and reducing the economic burden of FASD. Less is said about improving women's health and launching successful prevention. Although much drinking can take place in the early stages of pregnancy when women do not know they are pregnant, there are still no wide-ranging health promotion initiatives that would serve to effectively help women of child-bearing years reduce their use of alcohol generally, as well as improve their overall health in pregnancy so that FASD would be reduced or prevented.

While prevention and treatment of FASD is clearly on the national agenda, it remains a struggle to keep support and treatment of women—mothers and pregnant women—as a focus. Women-specific and women-centred alcohol and drug services have not been high priorities in addictions systems and are chronically underfunded. In Canada, Alberta is the only province that has a visible framework for women's alcohol and drug services (Alberta Alcohol and Drug Abuse Commission).

The impact of smoking on the health of women and their children receives much less attention in media and policy. This may reflect greater societal ambivalence about tobacco use in general because it is a legal substance but has *no* safe level of use. In addition, its overuse does not produce socially undesirable behaviours, nor does its consumption undermine women's social prescribed roles, whereas overuse of alcohol and any use of illicit drugs are unlikely to facilitate women's carrying out their roles. In addition, women smokers describe how smoking assists them in coping with difficult lives, stress, or poverty (Graham) and how tobacco use can assist in developing a socially endorsed image or identity (Greaves).

The one exception to this is smoking during pregnancy. A fetus-centric perspective in tobacco treatment mirrors legal and medical trends in maternal drug and alcohol use, as does the increase in fetal surgery, whereby the fetus is regarded increasingly as a "patient" (Casper). These trends have led to various suggestions for terms to describe the effects of tobacco use during pregnancy. For example, the terms "prenatal smoking" and "fetal tobacco syndrome," while not yet widely used, have been suggested to bring attention to the seriousness of smoking during pregnancy (Oaks 79-82). Laury Oaks reports that some advocacy groups suggest that newborns are addicted to nicotine when born (83). In addition to increased medical attention, these trends contribute to an increase in litigation about tobacco use in pregnancy and around children, often centring on family law, custody, or abuse and neglect claims (Greaves; Oaks) . For example, the ASH (Action on Smoking on Health) website exhorts separated and divorced parents to launch custody cases based on the issue of smoking around children.

The health interventions designed over the past 25 years to reduce smoking during pregnancy have not been resoundingly successful. While many women quit during pregnancy, both spontaneously and as a result of interventions, the relapse rate after birth is up to 90 per cent, according to some studies (Klesges *et al.*). The approach to smoking cessation during pregnancy has been motivated mostly by a desire to lessen the deleterious effects on fetal health. Therefore most interventions are framed around fetal health outcomes and are confined largely to the period of pregnancy. As a result, pre-pregnancy and post-pregnancy tobacco cessation interventions, which would focus primarily on women's health, have garnered proportionately less attention and emphasis. As Bobbie Jacobson claimed in 1986, "in rich countries, *most* women are *not* pregnant *most* of the time" (125), concluding that pregnancy tobacco cessation campaigns *ignore most women most of the time.*

In short, there is little emphasis on women's health in campaigns for both FASD reduction and tobacco cessation during pregnancy. Similarly, there is also little emphasis on context—how poor nutrition and other factors interact with substance use to affect perinatal health. Overall, women's health advocates have found it

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difficult to establish pregnant women's substance use as a women's health issue of concern to funding agencies and policy makers. As a result, all provinces lack services where women can access care with their children, women-specific detoxification services, or holistic, effective tobacco-cessation programs designed specifically for women, and health and social services that are welcoming and safe for pregnant women with substance-use issues.

Validating Substance-Using Pregnant Women

The issues involved in the Ms. G case were analyzed by Deborah Rutman *et al.* who concluded that there was a need for three key ideological "paradigm shifts": in the way substance use is treated and prevented (towards a harm-reduction/health promotion philosophy); in the mandate of child welfare (towards supporting families, not only protecting children); and in the way child apprehension is viewed (towards making social service systems accountable, not blaming mothers). They also reflect on how policy is disproportionately brought to bear on Aboriginal women who are pregnant, and how the conditions of Aboriginal women's lives make them more vulnerable to substance misuse.

Adopting a harm-reduction approach is a key suggestion for change that would validate women and their circumstances. Prevention of both alcohol and tobacco use during pregnancy would be improved by minimizing risk by encouraging reduction. There are several European examples that are models of harm reduction, where risk is calculated in a more fluid manner and decisions are made to support women as they minimize the risk to their fetus or child. A progressive example is the policy guideline published in 1997 by the Standing Conference on Drug Abuse (SCODA), associated with the local government associations in London, Scotland, and Wales (1997), which looks at how harms associated with maternal substance use are being addressed and how children's needs are being met in the context of possibly continuing substance use.

Essential insights on the effects of the policy and program environment on substance-using pregnant women or mothers often come from the women themselves and those who work and live beside them. Their insights provide a unique, but often unelicited, perspective on how policy affects and responds to women who are often experiencing a range of pressures and disadvantages. In a study where sample scenarios were put to women who had substance-using issues during pregnancy and early mothering, women spoke of the importance of context, and a new approach to risk assessment and decision making (Greaves *et al.*, 2002).

In their view, the fetus or child at risk is seen within the context of the mother herself needing help and being at risk for harming herself (the participants never fully viewed mother and fetus/child as separate). For example, the child's health was seen as at risk due to the mother's smoking, but the mother was seen as struggling with addiction. Similarly, Ms. G was seen as at risk for giving birth to further affected children—but also as needing help for her own sake and in her own interest.

Using the women's perspective, a different assessment of risk was generated, which varies from the official assessment. Instead of examining only the facts surrounding maternal substance use, issues such as the patterns of drug use, and the viability and importance of the mother/child relationship, were taken into consideration by the women in a more "reality-based" assessment of risk. In contrast to a child welfare approach that focuses on child apprehension, the women suggested a different distribution of resources that would see some going to support the mother to bond with, keep, and support the child, instead of all resources going into apprehension, fostering, or adoption processes. They felt that ensuring the unification of mother and child might be more productive in both the short and long term. For women who were familiar with these issues on a first-hand basis, the intensity and inextricability of the mother/child bond and the damage done to it through child apprehension were serious long-term issues, often overlooked in policy and practice. As one woman articulated it:

> *How is it good that the kid doesn't bond with the mother? How could it be that the child that you just gave birth to, this little person that is connected with you, like you just gave life to this child and then it's taken away from you, because you need to go through all the hoops that you were supposed to. Like, it's hard to quit drugs and they should be more empathetic to the mother and not just thinking whether it is safer for the child to go somewhere else.... Wouldn't it be better [than placing the baby into foster care] to have a group-type home with the mother and baby in the house together and to withdraw her that way?*

Some treatment providers are beginning to examine their relationship to the dominant woman-blaming discourses in policy and media and are making efforts to provide welcoming, holistic, harm-reduction-oriented, women-centred care that successfully engages pregnant women and ensures future health for *both* mother and child. For example, in the Fir Square Combined Care Unit at BC Women's Hospital and the Sheway Program in the downtown eastside of Vancouver, providers have pioneered approaches that support pregnant women's self-determination of the services they need and enact an integrated and balanced approach to the needs of the mother and the child. Fir Square provides in-hospital antepartum and postpartum medical care to substance-using women, and at the time of birth involves

mothers and a multidisciplinary team of health care providers together in the care of their newborns—it is an approach that supports the bonding and health of both mothers and infants. Most important, Fir Square is an "apprehension free" zone, preventing child apprehension by child welfare authorities in the period immediately following birth, while attachment and health stabilization are achieved and mothers' desires and needs can be assessed.

Sheway, a community program located in the downtown eastside of Vancouver, provides help with the full spectrum of nutritional, social, and medical and related practical needs of pregnant women and new mothers, making all forms of care accessible and free of judgement for women in pregnancy and in the postpartum period. This program has been evaluated and significant benefits in both women's health and infant health outcomes as well as reductions in child apprehension were found. The women served by Sheway appreciated the welcoming, respectful approach that allowed them to determine the type and extent of change they wish to make (Poole).

Some women's addiction recovery programs, such as the Aurora Centre (women's day and residential treatment program in Vancouver), are joining together with pregnancy-oriented services to smooth the transition to addiction treatment for pregnant women. This is accomplished by offering harm reduction and stabilization programming, such as short-term introductory group counselling where women can try to find balance and contemplate their readiness to change. Aurora is also successfully integrating tobacco cessation into its practice, to respond to the realities of women's substance-use patterns and to promote a women-centred approach to smoking cessation for women in alcohol and drug recovery.

Using the notion of harm reduction, women-centred tobacco treatment calls for buddy systems, incentives for low-income women, and the development of internal motivation to quit that will outlast the pregnancy. These interventions do not assume that every pregnancy is a happy event, or that partners are either present or supportive. Indeed, these new approaches are more reality based, dealing with issues of stress, violence, and stigma along with tobacco cessation (Greaves *et al.*).

Unfortunately, these kinds of approaches are in the early stages of development and acceptance in Canada. While promising holistic programming for pregnant women such as pregnancy outreach programs are being implemented in most provinces in Canada, there remains a long road ahead for these changes to be implemented on a system-wide basis supported by compassionate public policy, more progressive discourses, and new attitudes.

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Conclusion

Pregnant women have often been regarded by health promotion advocates as presenting a "window of opportunity" for behavioural change. This notion has been applied to issues such as encouraging tobacco cessation and alcohol reduction during pregnancy, or improving nutrition and sleep habits. But this attitude can be seen as opportunistic, paternalistic, and inherently sexist for its exclusive (and temporary) focus that renders women's reproductive value superior to women's health for its own sake.

This view of women's health for the benefit of the fetus is consistent with a long "uterine tradition" of understanding women's bodies and health (Matthews 17) where any commpromising of the fetus as a result of women's behaviour is taken seriously by society and women's ability to reproduce becomes the key reason to take notice of women's practices. Not only does this approach undermine women's health but it also produces guilt and self-blame in women who smoke and use alcohol and other drugs. This approach also allows stigma and punitive discourses about substance-using pregnant women to flourish. The alternative is to apply a critical analysis to practices such as women's substance use, where light would be shone on the material conditions and contexts affecting women's health in general.

As Oaks maintains, there is ample evidence that pregnant women are often reduced to being passive trustees of the fetus, not active makers of children (21). Regarding women as vessels in this way has translated into treating women merely or primarily as vehicles or stewards who are working on behalf of society. Growing interest in the conduct of pregnant women is a significant issue in Canada and forms a crucial backdrop to the overall discourse surrounding substance use during pregnancy in contemporary Canada.

As part of this discourse on pregnancy, pregnant women themselves

express a keen desire to do the right thing for their children, and want to create the healthiest conditions for their growth. They too see the advent of a pregnancy or the birth of a child as a significant life event where positive decisions can be made about someone else's welfare so an opportunity exists for redirecting their goals and will. Indeed, substance-using women often remark that their children were the best motivation for change. These feelings are positive and hopeful and offer an important clue for transforming policy and protocol to take advantage of women's motivations and strong desires to protect and nurture their children.

Validating approaches to dealing with substance-using pregnant women are women-centred, and address the issues and experiences that lead women to use substances. But overall, they value and support the mother/child bond, by dealing with both the health of women as well as the health of the fetus, simultaneously and with equal respect.

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