The Core Components of an Early Intervention Treatment Approach as Perceived by Substance Misusing Pregnant Women

by

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ABSTRACT

Literature on substance abuse and pregnancy indicates that something different needs to be done to help substance-misusing pregnant women. Most existing treatment models are reactive, addressing what should to be done after a child is born prenatally exposed to drugs or alcohol. Many pregnant women are motivated and want support for their addictions during pregnancy, but are reluctant to disclose their drug abuse due to multiple barriers, such as fear of child apprehension. Therefore, they deny their substance misuse, and the fetus continues to be at risk. In this study, I interviewed 10 women who had used either alcohol or illicit drugs while pregnant. Women were asked what aspects of intervention they identified as fostering treatment engagement? Findings indicated that many substance-misusing pregnant women deal with a number of struggles most of their life aside from their drug and alcohol use. Many of the women interviewed had experienced abuse, generations of substance misuse, lack of stability/relationships, and feelings of insecurity and invisibility, and their substance misuse served a coping function. Results indicated that treatment engagement by substance misusing women was facilitated by a collaborative relationship with their social worker. Results also demonstrated that children become motivators for positive change. Treatment, therefore, should include children as opposed to removing them. When their child was apprehended, many women fell deeper into their drug and alcohol misuse. Residential treatment programming that addressed both the women’s pre and post birth practical (i.e. housing) and mental health needs (i.e. their histories of abuse), and had professional supportive counselling as well as peer/mentorship groups, was considered ideal for treatment engagement.
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1 INTRODUCTION

Substance misuse during pregnancy is a growing medical and social concern (Marcellus, 2004). Prenatal drug abuse not only affects the pregnant woman and her child, it also has a significant impact on the whole community. Howell, Heiser, & Harrington (1999) identified that some drug-exposed infants cost the health care system more than non-drug exposed infants because of their need to stay in hospital longer after their birth. A study in the United States, of “one inner-city hospital found a difference of more than $5,000 in newborn costs between cocaine -exposed and non-exposed infants” (Howell et al., 1999, p.203). Even after they are released from hospital, a majority of these children are sent into the care of the child welfare system rather than the care of their biological mother/parents. Loock et al, (1991, cited in Vancouver Native Health Society) indicates that “In the early 90’s, data from a report entitled Targeting High Risk Families, revealed that approximately 1 in every 2 babies born in the Downtown Eastside of Vancouver were born substance affected and that 100% of these children were apprehended by social services at birth” (Vancouver Native Health Society, 2003). The most common reason that children come to the attention of child protection services is maternal substance misuse (Suchman, Pajulo, Decoste, & Mayes, 2006). In British Columbia, high rates of child apprehensions by child protective services in the Downtown Eastside have been found to be associated with alcohol and drug use by pregnant women (Payne, 2007, p.56). The Canadian Incidence Study of Reported Child Abuse and Neglect (excluding Quebec) reports that in 2003, there were a total of 103,298 child investigations across Canada. According to this study, based on a sample of 5,660 substantiated child maltreatment investigations, in about a fifth (1,122) of these
cases children tested positive for drugs at birth and in about half (2, 876) of these cases, children had “birth defects” related to substance abuse (Trocme, N., Fallon, B., MacLaurin, B., Daciuk, J., Felstiner, C., Black, T., et al., 2003). This study does not define birth defects but indicates that these defects are related to a biological parent’s use of substances that may cause Fetal Alcohol Spectrum Disorder (FASD). Furthermore, this study does not control for other factors such as nutrition, rest and housing.

As this problem becomes more rampant, mothers may become unable to care for children due to impaired functioning as well as lack of support, and foster care becomes necessary. This places a greater demand on the child welfare system. For example in the U.S., “the number of children in foster care associated with the ‘crack epidemic’ went up from 280,000 in fiscal year 1986 to 445,000 in fiscal year 1993” (Howell et al., 1999, p.199). However, placement in foster care does not ameliorate the problems associated with maternal substance misuse. A study by Billing et al. (1980, cited in Cosden, 1997) “found that children whose mothers continued drug use or who were placed in foster care were more likely to evidence speech and language delays and attachment problems than were drug-exposed children whose mothers had discontinued drug use” (p.3). Substitute care may not be the answer; it cannot cure these children and their inherent developmental problems. Often, these children do not get the care they require and their problems persist. Countless children who have been prenatally exposed to drugs and/or alcohol have been placed with in the foster care system for extensive periods of time, “which is itself a risk factor for the development of health, behavioral, and developmental complications” (Marcellus & Kerns, 2007, p.44). It is only when their mothers are given the support they need, that their children will benefit and have a better chance at life.
These issues are multifaceted. Therefore, it is vital to acknowledge the social determinants of health to better understand what one needs in order to achieve health. (Marcellus & Kerns, 2007) The social determinants of health as defined by Raphael (2004) are “socio-economic conditions that influence the health of individuals, communities, and jurisdictions as a whole” (p.1). In other words, these determinants ascertain who in our society will remain healthy or become unwell. The social determinants of health describe the range of resources available to members of particular social groups. The quality and quantity of “resources include—but are not limited to—
conditions of childhood, income, availability of food, housing, employment and working conditions, and health and social services” (Raphael, 2004, p.1). These conditions are defined by Health Canada and establish the necessary requirements for people who want to achieve good social health.

The social determinants of health help us to understand the social and environmental elements that contribute to the outcomes in the lives of substance misusing pregnant women and their newborn children (Marcellus & Kerns, 2007). Overall, many of these substance misusing women have experienced traumatic childhoods. They live in impoverished conditions, with limited supports and resources including low income and a lack of food and housing. As a result, when these young women become pregnant, they lack the necessary resources required for healthy living for both themselves and their children. The mother’s history, her current stressful living environment, and her maternal substance abuse all contribute to ill-health. Therefore, these three factors should not be treated as distinct entities but as one interrelated phenomenon. Furthermore, the
interrelationship of these factors cannot be fully understood without including the perspective of the women themselves.

Early intervention treatment programs provide a practical means to maintain the health of the mother, the fetus, and the child after birth. Healthy pregnancies/children will help to build healthier communities. Research indicates that women are “motivated to make healthy changes” when they become pregnant, while they are using drugs and/or alcohol (Kershnar & Paltrow, 2001, p.5). However, multiple barriers, including a lack of appropriate early intervention programs, may deter women from reaching out for assistance. Ideally, all barriers should be removed so that those women who are motivated have the opportunity to engage in treatment.

Barriers to women’s treatment and suggestions regarding ways of overcoming barriers have been described by various professionals (Poole & Isaac, 2001). However, the true experts, the pregnant substance misusing women, who live the reality and face these challenges daily, have not been thoroughly studied. This paper, therefore, presents the voices of women who have misused substances while they were pregnant.

Definitions. For the purposes of this thesis, the terms “addiction”, “chemical dependency” and “substance misuse/abuse/dependence” will be used interchangeably and be based upon the American Psychiatric Association (APA) diagnosis of substance dependence. This definition reads as follows: “The presence of a maladaptive pattern of substance use, resulting in distress or clinically significant impairment and involving at least three of the following symptoms (all of which occur within the same 12-month period):

• Tolerance
• Withdrawal problems
• Use of the substance longer than intended
• Unsuccessful attempts to control or reduce consumption
• Spending excessive amounts of time procuring, using the substance, or recovering from its effects
• Reduced involvement in important social, occupational, or recreational activities, and
• Continued use despite the presence of recurrent physical or psychological problems (APA, 2000, p.197 cited in Van Wormer, 2003, p.5).

Operationally, substance dependence in this study was defined as having been in receipt of substance abuse treatment inasmuch as all women were recruited through such treatment services. The term “prenatal exposure” will refer to the fetus being exposed to substances in utero.

1.1 Reflexivity

I have worked with diverse populations throughout my years of experience working in various social service settings. During this time, I discovered my passion for working in the area of pregnancy, particularly with youth. This passion motivated me in the work that I did. I currently work as a Social Worker at a Hospital’s Emergency and Extended Care Department and as a Youth Care Counsellor in a community environment at Options: Services to Communities Society.

On my case load at Options, I discovered that many of the youth I worked with faced a variety of challenges in their everyday life including poverty, alcohol, and drug use. Often when pregnancy was thrown into this mix, life became a lot more complicated for young women.

Many of these young women were consuming alcohol and using drugs during their pregnancy and were referred for drug and alcohol counselling. While many seemed to appreciate the referral, they had a difficult time following through. While they
expressed interest in seeking help for the sake of their unborn child, they also evidenced fear that prevented them from seeking the assistance they so desperately wanted. Many of these young women were living with generations of substance misuse as well as destitute living conditions. Many had experienced childhood abuse which was compounded by the trauma of being removed from their families by child protection services. Alcohol and drugs were used as coping mechanisms. My awareness of teenage pregnancy and addiction developed into a broader interest in prenatal substance misuse among women in their child bearing years.

Even though I had some experience/knowledge in the area of substance misuse and pregnancy, I had some reservations about approaching substance abusing pregnant women for this study. I was born and raised in a loving, middle class family. I have not been pregnant nor have I personally experienced struggles with chemical dependency and/or abuse. I could not personally relate to their social environments or their experiences of alcohol/illicit drug use during their pregnancies. I wondered whether the women would feel that I was qualified to represent their views. I therefore approached the women with respect and without judgment. I aimed to build a relationship of trust that would enable the women to describe conditions that could facilitate treatment engagement.

In summary let me say that altogether, the costs of substance misuse during pregnancy are high. If we look at the social determinants of health and consider that pregnant women are often motivated to make positive changes in their life it is obvious that these detrimental impacts of substance misuse on the child, women and community are preventable. However, multiple barriers continue to hinder women from engaging in
treatment. For this reason, it is important to understand what substance misusing pregnant women require to remove barriers and therefore, help them to engage in treatment. The research question is: From the perspective of women themselves, what aspects of intervention do substance misusing pregnant women identify as fostering treatment engagement?
2 LITERATURE REVIEW

This chapter begins with a brief history of women and substance misuse; it provides facts on the prevalence of women’s perinatal substance misuse in North America, and discusses the impacts of perinatal substance abuse on the child. Next, the contextual factors that contribute to a woman’s substance use are discussed.

2.1 History of Women's Substance Misuse Services and Research

Prior to the 1970s, there was minimal Canadian or American literature related to the treatment needs of substance misusing or addicted women (Field, 2000; Howell et al., 1999; Marcellus, 2004; Poole, 1997). In Canada, the problem of women and alcoholism had been prevalent since the 1930s, yet women’s addiction issues continued to be ignored (Field, 2000). Women alcoholics were viewed as deviant compared to their male counterparts. Women were blamed for their actions, and the social issues in their lives were not investigated (Field, 2000).

Finkelstein (1994) reported that “as recently, as 15 years ago, alcoholism and drug abuse were viewed primarily as men’s disease” (p.7). Even when women’s substance misuse issues became too difficult to disregard, their needs were not believed to be any different than the needs of addicted/chemically dependent men. For this reason, many of the traditional programs that originated to address addiction issues were built on male needs and interests and did not meet the specific psychosocial parenting and human reproduction needs of substance misusing women (Field, 2000). Finkelstein (1994) indicates that, “funders were reluctant to view women’s treatment issues as different from those of men and generally believed that women’s programming was not important
enough to deserve special attention” (p.9). For this reason, even up until the 1970s, gender-specific treatment programming was not available.

In the 1970s, The U.S. National Institute on Drug Abuse (NIDA) began to sponsor some substance abuse treatment program development for women (Howell et al., 1999). Their sponsorship included funds that supported the research and development of women-centred programs. Unfortunately, due to a change in government, funds were cut and very few women-focused programs continued to exist, even into the late 1970s.

Furthermore, Fetal Alcohol Syndrome was first identified in the American literature in 1973; however, in Canada discussion and actions did not begin until fifteen years later with a conference “sponsored by the BC FAS Resource Society, Sunny Hill Health Centre for Children and the University of British Columbia”, held in 1988 (Greaves, Poole & Cormier, 2002, p.2). Overall, several studies report that in the 1980s there was a shortage of substance abuse treatment services available to women (Howell et al., 1999).

It was not until the American government’s response to the crack cocaine epidemic in the late 1980s, that funding for treatment was made available. This reactive response from the American government stemmed from the increase in costs associated with children being exposed prenatally to cocaine.

During this time, there was increased public attention and American national interest associated with the effects on children of prenatal drug exposure (Cosden, 1997). Since the 1970s, there has been a steady increase in both the quantity and quality of research on women, as well as a growth in specialized women’s programming (Poole, 1997). However, “despite the increased support and availability of treatment programs, there exist serious barriers to treatment for pregnant substance users” (Lester, Andreozzi...
& Appiah, 2004, p.21). For this reason, pregnant substance misusing women are still "underserved" in the areas of prevention and treatment services.

2.2 Prevalence of Chemical Dependency and Pregnancy

At present, alcohol and drug misuse among pregnant women is a growing concern (Carter, 2002). In the past 10 years according to Field (2000), there has been a sharp increase in the number of infants born with birth abnormalities traceable to substance use by the mother during pregnancy. The BC Perinatal Database encapsulates all data on births in the Province. Kang (2003) reports that, “in the one year period (from April 1 2000-March 31st 2001) 1.9% of births were flagged for drug use (p.1). Within the city of Vancouver, Loock, et al. (1993 cited in Poole, 2000) report that “approximately 40 per cent of infants born over a two year period to mothers living in this area (downtown east side) of Vancouver were exposed to alcohol or other drugs in utero” (p.2). In Canada, based on the 1994 National Population Health Survey (NPHS) and the 1994/95 National Longitudinal Survey of Children and Youth (NLSCY), similar findings were revealed regarding the rate of alcohol consumption during pregnancy. It was reported that “17 % to 25% of women reporting drinking alcohol at some point during the pregnancy, and 7 % to 9 % reporting drinking throughout the pregnancy” (Roberts & Nanson, 2000, p.6). Population-based, Canadian data on the use of other substances during pregnancy is not available. However, in 1995, a US general population survey discovered that 2.3 % of women self reported using illicit substances during their pregnancy (Roberts & Nanson, 2000). Moreover, in the US, according to the NIDA, of the 4 million women who gave birth in 1992, over 5 percent of women used illicit drugs during their pregnancy. In other
words, an estimated 221,000 women who gave birth (in 1992) used illicit drugs while they were pregnant (Mathias, 1995). During pregnancy, some of the commonly used drugs are nicotine (20%), alcohol (19%), marijuana (3%) and cocaine (1%) (Kang, 2003). Recently, cocaine and methamphetamine have been shown to be the stimulant drugs of choice in North America, with methamphetamine quickly becoming the preferred drug over cocaine in many places around the world (Garcia-Bournissen, Rokach, Karaskov & Koren, 2006). Compared to cocaine, women seem to prefer methamphetamine and use it more often than men; it is estimated that 5% of pregnancies are exposed to methamphetamine in North America (Garcia-Bournissen et al., 2006).

Carter (2002) indicates that the incidence of women’s drug misuse during pregnancy has increased across different ethnic groups. In the U.S., of the 4 million women who gave birth in 1992, more than 5 percent used illegal drugs while they were pregnant. The NIDA (1992) survey that collected data from a national sample of 2,613 women who delivered their children in 1992 at 52 urban and rural hospitals “found that an estimated 113,000 white women, 75,000 African-American women, and 28,000 Hispanic women” self reported the use of illicit drugs during pregnancy (Mathias, 1995, p.1). “While African Americans had higher rates of drug use, in terms of actual number of users, most women who took drugs while they were pregnant were white” (Mathias, 1995, p.2). This study was the first to provide a national estimate of prenatal drug exposure as well as the quantity/types of use among a number of ethnic groups (Mathias, 1995).
2.3 Fetus to Child: The Impact of Drug Exposure in the Womb

Measurement of the impact of substance abuse on the fetus is difficult for several reasons. Much of the information about drug usage is self reported by women living among impoverished conditions, who have come to the attention of the authorities. Often, the genetics/health of the women, the amount of the alcohol or illegal drug(s) usage, the frequency of drug usage, and the stage of pregnancy when misuse occurred may not be known (Cook, 1997). Despite these difficulties in measurement, it has been suggested by Garcia-Bournissen et al., (2006) that children exposed to drugs or alcohol during pregnancy exhibit a threefold higher prevalence of major medical problems as compared to children not prenatally exposed to substances. Furthermore, prenatal use of alcohol and other illicit drugs is considered the “leading preventable causes of birth defects” (Drabble, L. & Tweed, 2006, p.10). Children who were prenatally exposed to alcohol and/or illicit drugs are at risk; they may experience many short- and/or long-term medical complications in areas of their psychological, cognitive, physical and social development (Cosden, 1997). The literature suggests that the various drugs may affect the fetus in different ways. However, recent findings indicate that the “accumulation of numerous risk factors appears to have a greater negative impact on child development than any single risk factor by itself” (Jones, 2006, p.126). Therefore, prenatal drug exposure is often one of the many risk factors that may negatively impact the health of a newborn child.

Alcohol is an accessible and legal drug in North American culture. However, safe amounts of alcohol use during a women’s pregnancy have not been determined. The abstinence from alcohol consumption during pregnancy is recommended by Canadian
professionals (Marcellus & Kerns, 2007). When children are prenatally exposed to alcohol, they may show signs of withdrawal including jitters, and difficulty feeding and sleeping. These children are also at risk of fetal alcohol spectrum disorder (FASD), including “a pattern of facial abnormalities, growth deficiencies, and central nervous system impairment” (Marcellus & Kerns, 2007, p.46). The severity of a child’s outcome varies. Although alcohol is legal and socially acceptable, “research shows that alcohol probably causes more long-term harm to the baby than most other drugs, including heroin and cocaine” (Marcellus & Kerns, 2007, p.46).

Children prenatally exposed to cocaine may be born with low birth weights and smaller head circumferences as “cocaine easily crosses the placenta” (Marcellus & Kerns, 2007, p.49). At birth, newborns may experience neonatal symptoms including tremors, high-pitched crying, “irritability, poor feeding, impaired habituation (an inability to tune out extraneous stimulation), gaze aversion, and disorganized attachment” (Marcellus & Kerns, 2007, p.49). Some studies indicate the effects of cocaine on a child’s development impacts their “expressive language and verbal comprehension, gross and fine motor development, learning, and behavioral” domains (Marcellus & Kerns, 2007). However, the reality is, only a limited number of studies that include children who have been prenatally exposed to cocaine, have actually followed these children beyond school age (Marcellus & Kerns, 2007). Also, not all studies take into consideration the confounding environmental factors that may exist in a mother/child’s life. Actually a recent longitudinal study that controlled for environmental factors showed that prenatal cocaine use was not associated with behavioral, mental and motor deficits (Messinger et al., 2006).
The primary concern of children who are prenatally exposed to opioids is their risk of withdrawal. For this reason, suddenly discontinuing the use of opioids is not recommended for the sake of the fetus. Newborns may experience symptoms including "irritability, high-pitched cry, increased muscle tone, sleeping and feeding difficulties, and gastrointestinal dysfunction" (Marcellus & Kerns, 2007, p.47). Also, premature delivery, miscarriage and high blood pressure risks may be amplified as a result of opioid use. Pregnant "women can be supported to stop or reduce the use of heroin (and other street opioid’s) through medically prescribed methadone" (Marcellus & Kerns, 2007, p.47). However when high doses of methadone are used during a pregnancy, there is still the risk of an intense withdrawal (Marcellus & Kerns, 2007, p.47).

There is limited information on both the short- and long-term impacts of prenatal amphetamine exposure. Reported effects on a newborn may include “tremors and hyperactive reflexes, poor feeding, disorganized sleep patterns, an initial hyperirritable stage sometimes followed by lethargy and poor feeding, and muscle tone problems” (Marcellus & Kerns, 2007, p.51). Long-term effects may include development delays and abnormalities associated with their “gross motor, fine motor, language, and social skills” (Marcellus & Kerns, 2007, p.51). However, conclusions on the effects of prenatal amphetamine exposure stress the importance of also considering the pregnant women’s environment as a possible risk factor.

The illicit drug used most often by women of reproductive age is marijuana (Marcellus & Kerns, 2007). It is difficult to isolate the effects of prenatal marijuana use from the possibility of other compounding factors that could impact the pregnancy; therefore, literature on these impacts remains contradictory. Reported effects include “the
risk of slightly lower birth weight and length and development of mild withdrawal symptoms, including increased startles and tremors, poor sleeping patterns, and poor habituation to visual stimuli” (Marcellus & Kerns, 2007, p.50). Also, there are inconsistent findings of the long-term effects of prenatal marijuana exposure (Marcellus & Kerns, 2007).

Even though the addiction of prescription drugs is beyond the scope of this paper, it is important to note that prescription drug addiction is an area of growing concern. Benzodiazepines (i.e. clonazepam, diazepam) have been used to help with depression, anxiety and insomnia. Regardless of the reason they are prescribed, benzodiazepines can be very addictive, often more debilitating than the addiction to cocaine or heroin. Their “withdrawal is recognized to be more difficult, more prolonged and can last months or years depending on the years of use, dosage and the concurrent prescribing with other drugs” (Gadsby, 2007, p.4). Therefore, it can be risky prescribing anti-depressants to women during their child bearing year, since safe amounts of use while pregnant have not been established (Gadsby, 2007). Altogether, prescription drug addiction and pregnancy can be devastating resulting in an increased chance of preterm birth, low birth weight and the death of a child (Boyd & Marcellus, 2007).

This general information on alcohol and a few popular recreational drugs used regularly by pregnant women reveals that substance misuse during pregnancy may not only impact a child in the short term but also effects him/her for the rest of his/her life. Howell (1999) points out that even though there are only a few studies in the area of long-term effects, research studies suggest that “long-term physical and behavioral development of drug-exposed infants is impaired” (p.199). Moreover, some infants born
to chemically dependent mothers do not show any signs of neurobehavioural problems at birth, yet begin to exhibit these signs later in life (Marcellus & Kerns, 2007). Overall, there is limited information on long term effects because during a majority of these studies the children were not being followed beyond their early childhood days (Marcellus & Kerns, 2007). Regardless, the effects of prenatal drug exposure cannot be examined alone without first also considering the context in which the mother lives as a risk factor for negatively impacting child development. The Maternal Lifestyle Study: Cognitive, Motor, and Behavioral Outcomes of Cocaine-Exposed and Opiate-Exposed Infants Through Three Years of Age concluded that “in the largest at-risk sample observed longitudinally to date, infant prenatal exposure to cocaine and to opiates was not associated with mental, motor or behavioral deficits after controlling for birth weight and environmental risks” (Messinger et al., 2004, p.1677). Therefore, the effects of cocaine and opiate exposure may be associated with other contextual factors. Maternal illicit drug use often highlights other associated environmental variables that may affect the well being of the child (Kerns & Marcellus, 2007 & Messinger et al., 2004).

Moreover, it is also important to keep in mind that, as exciting as new research was during the 1970’s and 1980’s, there were “many design flaws” in the studies that were looking at prenatal drug exposure and birth outcomes.

“These flaws included small sample sizes, high attrition rates (loss of participants), over representation of women in specific socio-economic, racial and ethnic populations, reliance on maternal self-reporting on frequency and intensity of use, and little or no consideration of multiple drug use or environmental and social factors...” (Marcellus & Kerns, 2007, p.44).
Therefore, it is difficult to conclude that the fetus/child is solely impacted by prenatal drug exposure without first looking at the possibility of other contributing factors. Cunningham et al., (1997, cited in Chase & Rogers, 2001) elaborates, “contrary to information in the popular media, not all substance-exposed children suffer the same poor prognosis. In fact, generalizations about the fate of drug-exposed children must await additional research into the outcome of the broader population of drug-exposed children, examining the roles of maternal and environmental factors” (p.42). Altogether, there is evidence that the contextual factors in a women’s life also impact the health of the fetus/child. “Children exposed to drugs and alcohol in utero suffer from the direct effects of the drugs on their developing physiology and from related environmental risks” (Cosden, 1997, p.3). Therefore, a conclusion can be drawn that child development is affected by not only prenatal drug exposure, but the context in which the child’s mother lives. “Prenatal exposure to both licit and illicit drugs mostly occurs in the presence of environmental and contextual risk factors that together can impede healthy outcomes” (Jones, 2006, p.126). The Maternal Lifestyle Study (2002) (cited in Jones, 2006) provides empirical data indicating that substance misuse during pregnancy often occurs “in the context of poly-drug use, lack of prenatal care, high rates of violence exposure, co-occurrence of other psychiatric problems, inadequate nutrition, and poverty” (p.127). Since prenatal drug and alcohol use often occurs in the context of other adverse factors in the women’s life it would suggest that treatment to be effective should not only concentrate on the women’s substance misuse/addiction issues, but also address the multiple negative environmental factors in which a pregnant woman may live.
2.4 Social Context of Substance Misusing Pregnant Women

Development of the fetus, infant or child is influenced by both "nature (the genetic or biological make-up)" as well as "nurture (the environment in which an infant or child lives and grows)" (Marcellus & Kerns, 2007, p. 47). This suggests that surrounding environment in which the fetus or child lives and grows is influenced by past and present circumstances in the mother's life. Most substance using women come from families with histories of trauma, substance use, family violence, abuse, poverty and homelessness (Marcellus & Kerns, 2007; Cosden, 1997; Finkelstein, 1994; Howell et al., 1999). These underlying issues often are associated with the women's drug use (Rutman, Jackson & Field, 2000).

There is evidence that a disproportionate number of women with substance abuse issues may have experienced childhood sexual and/or physical abuse (Rutman et al., 2000). According to Howell et al. (1999), "61% to 75% of women in substance abuse treatment reported experiencing sexual abuse some time in their lifetime" (p. 198). Their alcohol or drug of choice appears to fill an unmet need; it provides comfort, control and an escape — "but it does so less and less as the disease progresses" (Zelvin, 1999, p. 13). For many, their substance misuse is their only learned coping mechanism: "a self-administered narcotic to numb or dull the pain of sexual and/or physical abuse" (Rutman et al., 2000, p. 98). Furthermore, many women self-medicate as a way of getting through their underlying feelings of depression that have resulted from forcibly living in impoverished conditions (Cook, 1997; Cosden, 1997). A chemically dependent pregnant woman's environment entails limited resources and creates multiple barriers which prevent them from seeking proper prenatal. Overall, "children most at risk of impairment
come from highly dysfunctional heavily drug-involved families, where chemical abuse is only one of the multitude of problems” (Cook, 1997, p.67).

Altogether, as cited previously by Field (2000) the issue of women and substance misuse has been prevalent since the 1930’s. Yet many treatment programs continued to be created based on the needs of men (Field, 2000 & Finkelstein, 1994). Even though treatment programming for women has increased since the 1980’s, pregnant women who misuse substances continue to be underserved (Lester, Andreozzi & Appiah, 2004). As a result, this is an area of growing concern as more and more children continue to be at risk for compromised child development due to prenatal alcohol and/or drug exposure. Often it becomes difficult to determine, the exact impact of each drug on the fetus, due to fact these outcomes are frequently determined by the women’s willingness to self report the amount, and frequency of their alcohol, drug and/or multi-drug use. For example, women may under report their use, due to their fear of child apprehension. Regardless, substance misuse during pregnancy impacts the child in both the short term and often for the rest of his/her life. However, research indicates that child development is not only affected by prenatal drug and/or alcohol exposure but also by the environment in which the women live. Therefore, when looking at treatment for substance misusing pregnant women and the impact of their use on their child it is important to consider the contexts in which the women live which often includes limited resources. Also repeatedly women use alcohol and drugs as a coping mechanism to numb their pain from their own histories of abuse and trauma.
3 TREATMENT

In this chapter, ethics of treatment for pregnant substance misusing women are identified and the child protection process is considered. Treatment models are presented, and barriers to treatment that hinder chemically dependent pregnant women from receiving the help they need for their substance misuse or addiction(s) are reviewed. The importance of a substance misusing pregnant woman’s perspective is discussed. The literature review concludes by revealing the research question and how this study can contribute to the research that has been completed in this area.

3.1 Ethics of Treatment

Ethical considerations regarding the treatment of pregnant substance abusing women primarily relate to the conflicting rights of the fetus to protection versus rights of women to autonomy. Marcellus (2004) defines autonomy as “the right of a competent person to make decisions for themselves” (p.733). She goes on to indicate an essential caveat: “Autonomy can be achieved only when the social conditions that support it are in place” (Marcellus, 2004, p.733). Five distinguishing features of autonomy have been identified: independence, the capacity for decision-making, judgment, knowledge, and self determination” (Keenan, 1999 cited in Marcellus, 2007, p.31). This raises the question of whether substance misusing women who have experienced histories of abuse, substance use and poverty throughout their life can be expected to possess these characteristics (p.31). Alternately, when the rights of the fetus are given priority, protective interventions are often justified through the principle of beneficence (Marcellus, 2007). Beneficence can be described as the injunction to “do no harm” (Cook
1997; Marcellus, 2004). Mandatory treatment for women is frequently prescribed under this principle and even strict interventions such as incarceration have been suggested because of the women's criminal-like actions towards the fetus (Lester et al., 2004). Arguments against this position have been based on observations that mandatory interventions further discourage women from accessing prenatal care or treatment (Marcellus, 2007). Instead, it is suggested that substance misuse be regarded as a "mental health/medical illness" with strategies that put emphasis on "treatment and prevention" including prenatal care, parenting/relationship building and support with childhood trauma (Lester et al., 2004). However, regardless of whose rights are given priority, regardless of whether coercive punitive treatment or voluntary non-punitive treatment is recommended, Lester et al. (2004) indicates that treatment for substance abusing pregnant women is necessary.

3.2 Ethics in Action in North America

Toxicology screening is the most common way to determine whether or not a pregnant woman is using drugs while she is pregnant. In the US, prior to March 2001, when women tested positive on mandatory screens, these results were used as evidence of child abuse. On March 21, 2001, the U.S. Supreme Court ruled that it is unlawful to involuntarily test pregnant women who are suspected of drug abuse (Carter, 2002). Poor women of color were criminalized far more than other women, because they were giving birth in public health settings. Delivering in these facilities increased their chances of incarceration compared with middle-and upper-income women who gave birth in private hospitals that were rarely screened for illicit drugs (Carter, 2002), resulting in
perpetuation of poor women’s oppression. It is interesting to note that “in the United States, women who have challenged their charges have succeeded in almost every case in reversing penalties imposed on them for their prenatal conduct” (Marcellus, 2007, p.32).

In Canada, the fetus is not considered a child until after birth. This “guarantees that prosecution based on prenatal conduct will continue to be unsuccessful in Canada, as the interests of the fetus do not have legal rights or status within Canada’s criminal code” (Marcellus, 2004, p.735). Research findings present the many consequences of prosecution/mandatory treatment. In Canada, “mandatory treatment was seen to be of little value. A woman who was not interested in treatment would not benefit from treatment and would just rebel if forced into treatment” (Rutman et al, 2000, p.103). Women feared mandatory treatment; this pushed them further away from accessing prenatal care, creating more harm than good (Cook, 1997). According to Carter (2002), Haugaard (1998) and Marcellus (2004) there is a general consensus in the literature that voluntary treatment and a medical intervention is preferable over mandatory drug treatment or a criminal intervention for chemically dependent pregnant women. “It is important to note that in Canada, all prosecution efforts have been thwarted and women’s rights upheld” (Marcellus, 2007, p.32). Yet, some community members continue to insist on trying to criminalize substance misusing pregnant women (Marcellus, 2007).

3.3 Child Protection and Substance Misusing Pregnant Women

The Child, Family and Community Service Act (1996) of British Columbia mandates that anyone who suspects that a child is being abused or neglected must report this to a child protection social worker. The Act defines a “child” to mean a person under
19 years of age and includes a youth, and therefore there is no legal necessity to report suspected abuse of the unborn fetus.

Despite the restriction of the Act that it does not include a fetus in the definition of child who may need protection, the provincial Ministry of Children and Family Development (MCFD) has developed policies that aim to provide assistance to substance misusing pregnant women. For example, Policy #: 2006-03 OP—*Reports of Pregnant Women Whose Behavior or Health are High Risk*, MCFD encourages service providers, health professionals and community members to report pregnant women whose actions or circumstances are posing a threat to the well being of the fetus (Fraser Region Operating Policies and Procedures, 2006-03 OP, p.1). Examples of concerns that the community could have include the “physical or mental health of a pregnant woman, concerns about a developmentally delayed mother to be, or concerns about a dangerous lifestyle that could endanger a future child” (Fraser Region Operating Policies and Procedures, 2006-03 OP, p.1) including substance misuse of alcohol and/or drugs.

All reports made prior to the birth of a child are viewed as only a “request for support services”. The intake and assessment team reviews all received reports. Information can be collected through a voluntary process. If a concerned third party is calling, where appropriate, the child protection worker would disclose their concerns, with the third party’s consent, to the pregnant woman in the hopes of collaboratively working together to address any identified issues. “The child protection social worker will attempt to assist the pregnant woman by offering support service referrals aimed at reducing the risk of harm to an expected child and to support healthy family development” (Fraser Region Operating Policies and Procedures, 2006-03 OP, p.2).
A pregnant woman could either accept the support of a social worker or reject it. If the woman agrees to work with a social worker this policy stresses the importance of relationship building, being respectful, nonjudgmental, creating rapport and trust with the woman. Social workers are directed to explain their child protection role versus their interests; the social worker’s interest includes working collaboratively with women towards their goals. The policy states that the immediate needs of any woman should be first addressed as part of any intervention, including practical or mental health needs. “Needs could include basics such as clothing, food, housing and medical care, and could include counselling, therapy, or detoxification services” (Fraser Region Operating Policies and Procedures, 2006-03 OP, p.3). Referrals to other support services can be made if the woman consents.

The policy goes further to indicate the importance of exploring the natural helpers in the woman’s life (i.e. family, friends or organizations), and setting up safety plans, as required, for week-ends and after-hours. Also brings forward the idea of introducing the women to an integrated case management/"wrap around" team to help her achieve a sense of partnership, and provide her with an opportunity to learn about available options as they relate to her needs.

As the time for delivery nears, consultation with the woman and the “care team” is required to sort out whether or not the hospital should be alerted or made aware of the possible complication with the woman’s upcoming pregnancy. This is relevant since it would prepare the medical staff to help implement timely services in accordance to what has been previously agreed upon by the woman and her care team.
Social workers cannot enforce any interventions with a substance misusing pregnant women without her consent. Therefore, if a pregnant woman whose behaviour or health present a risk to the fetus decides that she does not want to work with a social worker the policy outlines an alternative approach. Women are offered referrals to other agencies. The policy states that the file should stay open during the length of the pregnancy, in an effort to stay in contact with and support this woman through her pregnancy. The aim of this would be to reduce harm; this is considered best practice and it is the desired approach in most situations.

However, if the woman is not interested in any support or contact even after a thorough attempt by the social worker and if the assessment has determined “that the child will be at immediate risk of serious harm at birth, or is likely be at risk or serious harm following birth, [then] all Lower Mainland Hospitals should be notified of the mother’s high-risk situation and anticipated date of delivery” (Fraser Region Operating Policies and Procedures, 2006-03 OP, p.3). Regardless, of the hospital in which she gives birth, the alert will ask that a member of the medical staff contact the Ministry for Children and Family Development when her child is born. After the child is born, the well-being of the child may become a child protection issue.

According to the Ministry for Child and Family Development (Lee Rudance, personal communication, March 7, 2006) when a call is received from the hospital in regard to an alert, or if a community member or professional makes a child protection report, the child protection social worker will assess or reassess the family and infants current risks, and take the steps necessary to protect the child or children. The Ministry for Children Development (1996) regards “the safety and well being of the children [as]
paramount considerations”. These action steps that need to be taken to protect a child are determined by a Comprehensive Risk Assessment. “This is the process of assessing the risk of future abuse and neglect of a child” (The Risk Assessment Model for Child Protection in BC, 1996). The comprehensive risk assessment includes 23 risk factors that need to be considered when determining harm to children. Of these, one key element to note includes rating the women’s alcohol and drug use as an important risk factor.

According to the comprehensive risk assessment, alcohol and drug use are factors that have a large impact in determining a women’s capability for caring for her child. “…In the majority of child protection cases the substance use of one or both parents is a primary concern” (Field, 2000, p.15). This includes a woman’s current substance use, as well as her history of addiction. The Ministry for Children and Family Development’s assessment guidelines note that “the best predictor of future harm is past history; the greater the past problems, the higher the risk” (The Risk Assessment Model for Child Protection in BC, 1996). Also, women continue to be stigmatized; it is assumed “that drug use equals poor parenting and that substance-using mothers are unable to care for their infants due to their special needs if diagnosed with neonatal abstinence syndrome” (Boyd, 2007, p.16). As a result, regardless of whether a woman is currently using or not, her newborn child or children may be removed and temporarily or permanently put into a foster home. Foster parents frequently fear they are not well equipped to provide care to infants who are prenatally exposed to either alcohol or illicit drugs. Often after being placed in a home, children are removed and re-placed due to difficulties experienced by foster parents. Therefore, there continues to be a lack of placement options for these vulnerable children, who often have complex needs (Lester et al, 2004). Field (2000)
declares that the removal of infants from their mothers at birth is inopportune since “a mother’s attachment to becoming a mother and desire to care for her infant has provided the basis for what has been seen by professionals as a window of opportunity for professional intervention” (p.5). Therefore, it can be argued that child apprehension is a failure of the system that neglects to address and meet the needs of substance using mothers.

When children are placed in foster care, mothers may be mandated to seek alcohol and drug counselling and/or treatment as a condition of having their children returned to them. However, this mandatory treatment may well be unproductive, for “mandatory treatment...reproduces and reinforces the oppression that contributes to women’s substance use in the first place” (Rutman, Callahan, Lundquist, Jackson, Field, 2000, p.v). Often women are taken out of their social contexts for the purpose of treatment, and later returned with their children to the same environments, without any of the supports that they need. Unfortunately, “… women are in a vulnerable state following residential treatment. Understandably, they become overwhelmed and start using again: they are still poor, isolated, and without supports, all of which lay the foundation for continued use” (Weaver, 2003, p.13). This can become a vicious cycle.

3.4 Treatment Models

Substance misuse is an area of study that has evolved through many stages over the last century. There have been modifications in the “belief about the basic nature of addiction, or substance dependence, how to prevent its occurrence and how to intervene once dependence has become established” (BC Planning Framework for Problematic
Substance Use and Addiction, 2004, p.71). Substance misuse has been viewed in many ways, as an individual choice, a disease that one has no control over, a behavioural disorder, or a condition resulting from stressful and debilitating life situations. These specific beliefs become the basis of diverse treatment approaches, including the disease/medical model, the biopsychosocial model and the women centred/harm reduction models. These different models lay the foundation for the separate treatment services available for substance misusing pregnant women (BC Planning Framework for Problematic Substance Use and Addiction, 2004).

3.4.1 Medical/Disease Model

The medical model identifies addiction as a disease which is caused by “genetic and biological factors” (BC Planning Framework for Problematic Substance Use and Addiction, 2004, p.72), and views those with substance misuse issues as patients requiring treatment (BC Planning Framework for Problematic Substance Use and Addiction, 2004). This model emphasizes that women are powerless over their addiction and, as a result, not held responsible for a disease they are unable to control. According to this model, chemical dependence needs to be treated before any other issues in the women’s life can be addressed successfully. It is also understood that treatment becomes necessary when one is physically dependent, is unable to manage excessive amounts of consumption, evidences increased tolerance for substance consumption, and is accompanied by withdrawal symptoms/cravings (Athabasca University, 1997).

The success of treatment is measured by abstinence because abstinence is considered the sole goal for all substance misusing women. According to this perspective,
addiction is a lifelong illness that can never be cured, only detained if the woman refrains from using alcohol or illicit drugs (White, R. & Wright, D., 1998). Medically based treatment includes prescribed antidipsotropic medications and for “severe dependence” detoxification and outpatient programs like Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) are recommended (Athabasca University, 1997, p.2).

Alcoholics Anonymous (AA), 12 step type interventions are based on the belief that addiction is an incurable disease that progresses quickly if women are not committed to lifelong abstinence (BC Planning Framework for Problematic Substance Use and Addiction, 2004). In this type of program, participants are taking 12 steps toward recovery, beginning with admitting that they are powerless over their addiction. They have to come to a place where they are able to turn their lives over to a greater power (i.e. God, as they understand him). This power will then support them through their recovery, step by step (Alcohol Anonymous World Services, 2007).

The medical/disease model of addiction can be viewed as beneficial in assisting woman to understand that her behaviour is not intentional, rather both she and her family have suffered from the “consequences of alcoholism and drug abuse and that during her period of drinking and drug use, her options were limited” (Finkelstein, 1994, p.14). Also the fellowship aspect of this self help group is often viewed as its greatest benefit.

The limitation of this medical/disease theory of addiction and the corresponding AA treatment model is its lack of focus on gender; the basic assumptions of this model come from the observations of largely upper middle class, white alcoholic men (Kasl, 1991). Although some AA groups are specifically designed for women, some women may perceive this notion of powerlessness as disempowering. Furthermore, treatment
programming without professional input may be limited in its ability to help women fully recover, especially when their struggles go beyond their substance misuse. Also, this AA models one preferred goal is abstinence; this can be viewed as a narrow measurement of success.

Stemming from this traditional AA model is Charlotte Kasl’s 16-steps for Discovery and Empowerment model. This empowerment model is based on the belief that addiction is a complex issue involving social issues, physical pre-disposition and individual histories (Kasl, 1991). This 16-Step model goes beyond the AA model, empowering women to take control of their lives rather than surrendering to a power greater than them. This model takes into account the different ethnic groups. It highlights the importance of women recognizing their underlying issues, including “internalized oppression and cultural diversity” as a means toward healing and recovery.

3.4.2 Biopsychosocial Model

The biopsychosocial model takes a holistic approach to the nature of addiction/substance misuse. Substance misuse is considered to be a product of an intricate exchange among a “combination of biological, psychological, social and spiritual determinants” (Adult Addictions Services Branch, 1996, p.6). The biology of substance misuse is influenced by heredity. The psychological component considers thought process that guides drinking or drug use. For example, a woman may use drugs and/or alcohol to try and escape her underlying issues of depression. The social component considers the environment wherein addictive/ substance misuse occurs and the impact of such misuse experienced by the individual (Van Wormer & Davis, 2003).
Social class is considered an important factor; “the disadvantaged are more likely to suffer alcohol-related problems, even when drinking at the same level as more economically privileged groups, because they lack the material resources and often the social supports available to others” (Van Wormer & Davis, 2003, p.12). This approach helps to understand the vicious cycle of addiction and other contributing factors, using a holistic approach (Van Wormer & Davis, 2003).

According to this model, there are several ways to think about and intervene in the area of addiction/substance misuse. There is a continuum of severity when it comes to substance misuse. The biopsychosocial model focuses on “the need to respect the unique circumstances and perspectives of each client, but it also supports a view of individuals as powerful agents for self-determination” (Addictions Foundation of Manitoba, 2000, p.5). Therefore, treatment options would vary depending on how addiction is experienced by the different individuals. “Successful treatment is contingent upon accurate and comprehensive assessment and matching of affected individuals to the most appropriate treatment” (Adult Addictions Services Branch, 1996, p.6). For that reason, abstinence is not the only requirement for recovery. As an alternative, this treatment model considers the multiple new or old issues that are connected to the individual’s substance misuse which also need to be addressed.

This holistic approach has many strengths. This model takes into consideration the varying factors in an individual’s life before considering and implementing a specific intervention. Also the emphasis on individual empowerment where abstinence is not the only recommended outcome that measures recovery/treatment success is beneficial.
The limitation of this model is its abstractness; no specific interventions are prescribed. Also, there is the specific lack of a gendered analysis where the needs of women are not identified.

3.4.3 Women Centred Harm Reduction Model

This model is based on the biopsychosocial notion of addiction with an emphasis on the gendered nature of social organization. Harm reduction treatment begins where the person is at; “harm reduction is an umbrella term for a set of practical strategies based on motivational interviewing and other strengths-based approaches to help people help themselves by moving from safer use, to managed use, to abstinence, if so desired” (Van Wormer & Davis, 2003, p.27). This woman-centred harm reduction model, furthermore, addresses gender specific needs as essential components to a woman’s recovery and well being. For example, the needs of women as they are identified by her, while pregnant and post birth are taken into account as a part of any treatment intervention. Women define the problem and strategies are developed with women to consider an array of solutions. Services are holistic, flexible and accessible to ensure that the specific needs of women are addressed such as child care and education (Field, 2000). Furthermore, this model incorporates a relational model of treatment where women’s relationships with others are seen as strengths as opposed to problems. The aim of this treatment model is to develop strategies for empowering women as opposed to further pathologizing them…” (Field, 2000, p.3).

Abstinence is merely one of the many options in harm reduction. “Abstinence may be an ideal outcome for many addicted persons, but harm reduction advocates point
out we are not 100% effective in convincing people to become abstinent” (Van Wormer & Davis, 2003, p.70). Interventions look at reducing harm in relation to their substance misuse, not necessarily to decrease the amount of their consumption. Therefore, a harm reduction approach could vary depending on the diverse needs of women. For example, some women may understand harm reduction as a step by step reduction toward abstinence. For other women, it may mean substituting their current drug of choice for a less harmful drug, or decreasing the amount of drug intake/multi-drug use and/or increasing healthy eating habits (Kershnar & Paltrow, 2001). This approach concentrates on a healthy way of living, working toward reducing harm to those aspects in a client’s life that she believes to be significant/immediate and not on the issue of substance misuse, per se (Van Wormer & Davis, 2003).

Harm reduction is an important element of woman centred care where professionals work collaboratively with women, attending to their distinct and shifting needs during their life cycle. In relation to substance misusing pregnant woman, “harm reduction starts with the knowledge that pregnancy is a time that women are very often motivated to make healthy changes in their lives and that pregnancy provides a window or opportunity for social and health services to support such change” (Kershnar & Paltrow, 2001, p.5). Therefore, it is vital that programs identify and build on the presenting strengths of a pregnant substance misusing women (Kershnar & Paltrow, 2001). “Women-centred, harm reduction programs offer compassionate care and positive maternal outcomes and family support” (Boyd, 2007, p.27). Women centred harm reduction programs can be successful when mothers are not separated from their children
(Kershner & Paltrow, 2001) and are seen as members of community into which they require support for re-integrating (Health Canada, First Nations & Inuit Health, 2006).

The benefits of the woman-centred harm reduction model are its emphasis on the specific needs of women related to pregnancy, child-birth and childrearing. This models emphasis on empowerment of women is ideal.

The limitations of the women-centred harm reduction model are the lack of substance misusing women’s voices in the development of the model.

3.5 Barriers to Treatment

Numerous barriers that prevent pregnant women from seeking treatment for their substance misuse issues have been identified. Primary barriers include women’s fear of stigmatization and fear of judgment (Carter 2002; Finkelstein, 1994; Poole & Isaac, 2001, Weaver, 2007). Women feel guilty that they are unable to attain what they believe are the expectations of society. Fear of child apprehension (Finkelstein, 1994; Marcellus & Kerns, 2007; Poole & Isaac, 2001) is a well documented factor. Women dread the thought of losing a new-born child with whom they look forward to developing a bond. Another barrier includes denial of addiction or a belief that it can be managed alone (Finkelstein, 1994; Poole & Isaac, 2001). Some women do not completely recognize the implications of their alcohol or drug use. They do not have the information and resources they each require. Moreover, barriers include a “fear of prejudicial treatment on the basis of their motherhood/pregnancy status and feelings of low self-esteem” (Poole & Isaac, 2001, p.12). Many women believe that they will be judged and treated poorly in treatment and refuse to put themselves in such a situation.
Finkelstein (1994) summarizes these barriers:

Many women do not enter treatment because they do not wish to put their children in foster care; they fear they will lose custody of their children; and believe, as society does, that they are terrible people and bad mothers. This extreme guilt and shame keeps them in denial and out of treatment (p.11)

Other systemic barriers include the attitudes of professional/providers, a lack of gender specific treatment services (Beckman 1994; Finkelstein 1994; Carter 2002), absence of staff training (Howell, 1999), lack of continuity of professional staff with whom they have managed to develop a relationship due to high staff turnover (Perrin, 2006), distrust of the health care system (Carter, 2002), lack of child care options (Howell 1999; Haugaard, 1998), “lack of information about what treatment was available, waitlists for treatment services” (Poole & Isaac, 2001, p.12) and the overall lack of treatment services for drug-addicted pregnant women. Furthermore, not enough programs “allow women to retain custody of their children and to care for their children while in treatment” (Leslie & Roberts, 2001, p.23). Women become reluctant to seek treatment due to the quantity of time that may be required to spend away from their child’s life (Lester et al., 2004).

Overall, there is limited information and programming that addresses the needs of those women who become pregnant while using and even those limited programs that do exist, many women do not have the practical means required to access this support (Lester et al., 2004).
3.6 Importance of Women’s Perspective

Substance misusing pregnant women need to have the opportunity to speak about what they need to help them to engage in treatment. “Within the literature we found a disproportionate volume of material that was about substance-using women; however, we heard far too little that was directly from them” (Field, 2000, p.18). It is very important that we involve these women in conversations about their needs, especially since “there is certainly a window of opportunity in prenatal care, as women are more likely to engage with the health care system and abstain or reduce their substance use, many for the first time ever” (Kang, 2003, p.2). Women are the experts of their own life. Therefore, it is important that they are consulted with when it comes to treatment issues that affect their life. Substance misusing women can add to our current literature to help us understand how to address these multiple barriers that continue to hinder them from accessing support services when they become pregnant while using alcohol or drugs.

3.7 Summary and Research Question

Research on women, addiction and pregnancy has come along way since the 1970’s. Today there is valuable information to help professionals working in this field. Substance misuse during pregnancy has several consequences to the mother, her children and the community. However, we also know that the health implications faced by a newborn go far beyond just the women’s substance use. There is evidence that treatment for drug addicted pregnant women needs to encompass their impoverished contexts. A major barrier to women’s help seeking has been fear that they will lose their children to child protective services if they seek out support. A number of treatment models have
been developed that can be used as a foundation to build or enhance support services for this population. The woman-centred harm reduction model is one that is increasingly utilized as service provider’s work together to address this area of growing concern.

While various treatment models have been developed, the voices of substance misusing pregnant women are not always reflected in the development of such models. The research question for this study aims to fill this gap by asking the question: From the perspective of women themselves, what aspects of intervention do substance misusing pregnant women identify as fostering treatment engagement?
METHOD

This chapter will explain how women who used substances while pregnant were recruited. These women and the context in which they live will be introduced. The data generation and analysis processes will be reviewed. The validity of this study will be presented.

4.1 Recruitment/Sampling

The recruitment process followed receipt of approval from the University of British Columbia's Behavioral Research Ethics Board (BREB). Women were recruited using criterion sampling. The criteria stipulated that women must be between 19 and 45 years of age. If they were pregnant, they needed to be at least four months pregnant, and if they had already given birth, their child needed to be 5 or younger. They must be either using alcohol or illicit drugs during pregnancy, or have had used alcohol or illicit drugs while pregnant. Finally they must be able to speak fluent English.

Three sites, Vancouver Area Network of Drug Users (VANDU), Peardonville House Treatment Centre and Options: Services to Communities Society, agreed to participate in the study. Each site was provided with recruitment posters (see Appendix A) that were displayed as a form of advertisement. Agencies received invitation letters (seen Appendix B) that were distributed to women who were interested in the study or to women whom they felt met the selected criteria for the study. With the help of a contact person at each agency, a time to present the purpose of my research to the women was arranged. After each presentation, women who were interested in participating in this study approached me and we set a time to meet for an interview. My contact person at
each agency also kept the names and contact data of those women who were interested in the study but, were unable to attend the presentation. With the permission of prospective participants, the agencies forwarded their contact information to me.

4.2 Participants

A total of ten women who responded met the eligibility criteria; seven women were from Peardonville House Treatment Centre, two from VANDU and one from Options: Services to Communities Society. These women agreed to participate in one—one hour interview and possibly a second follow-up interview, as needed (the maximum time commitment was two hours). Their childhood stories were a way of understanding and processing their current circumstances in adulthood. Pseudonyms have been used to maintain the anonymity of the participants.

4.2.1 Angie

Angie describes her father as an alcoholic and her mother a prostitute. Angie recalls a time when she was two and a half years old; her father pointed a gun at her mother, as he threw Angie into her crib, breaking her ribs and both her legs. Angie was taken into foster care with her body in a cast. Angie indicated that this was a very traumatic time in her life; which she still has nightmares about. Angie grew up with loving foster parents; however, her childhood history continued to haunt her. With the intent to minimize the pain she felt, Angie began drinking at the age of thirteen.

At the age of 29, Angie met her future husband, a heroin addict, who introduced her to cocaine. Angie became pregnant at the age of 29; her son was born with FAS, she
indicated that no one told her she was not supposed to drink and use cocaine while pregnant. Angie had three other children since her first, all of whom have been apprehended due to her substance misuse. Her most recent pregnancy was in 2002, when she gave birth to her 6 lbs. 5 oz. daughter. Angie indicates that this fourth child was also removed directly from hospital even though they found no drugs and/or alcohol in her. Angie felt judged by Child Protection Services since they apprehended her daughter based on her history although she had made positive changes during this pregnancy. Angie was working toward making positive changes in her life for the sake of her unborn child; she had stopped using alcohol and drugs. Yet her efforts went unnoticed and since then, Angie has further fallen into her addiction.

4.2.2 Francis

Francis recalls growing up in and out of foster homes due to her mother’s drinking and due to the abusive men in her life, one whom attempted to sexually assault her, while another three men (cousins and uncle) of whom she trusted, did sexually assault her. Francis explains the lack of stability and inconsistency in her life while she was growing up. She grew up as the caretaker of her siblings, while her mother was lost in her addiction. Francis began using illicit drugs and alcohol at the age 15. Francis recalls drinking, doing lines of cocaine and then straight to needles. It was when she had sex with a guy for a fix that she realized she needed help. Francis checked herself into detox at the age of 16; however, she was discharged back into the same living conditions she had tried hard to escape; nothing had changed. At the age of 17 she became pregnant. Throughout this pregnancy she smoked pot. Francis had three more children close in age.
and then her fifth child seven years later and during these pregnancies she smoked crack cocaine. All her children were apprehended; she fought hard to make sure that she did not lose her fifth child. During this last pregnancy, she checked herself into drug and alcohol counselling and began taking prenatal vitamins. Francis succeeded in altering her use, but the nature of her environment made it difficult for her to completely refrain from using. Her child was apprehended; but returned to her when she entered into treatment. Francis continued to deal with generations of substance abuse within her family.

4.2.3 Linda

Linda describes her childhood using the terms “chaotic and dysfunction”. Linda states that she grew up with a mother who was an alcoholic drug user. Linda recalls being apprehended sometime before she turned ten. Linda began smoking marijuana and drinking alcohol at the age of twelve. Linda’s alcohol consumption increased with time and she was heavily consuming by the age of fifteen. She began skipping school or going to school drunk. Linda was introduced to Narcotic Anonymous (NA) but did not care for it. Between the ages of 16 to 17, Linda was smoking crack cocaine. She began working on the streets, as a way of making money to help pay for the drugs. For the first part of her pregnancy she recalls living in a crack house. Linda did not know a life without alcohol or drugs, yet when she became pregnant, for the first time she altered her use. Linda indicates that she would use and then stop for a week and then use again. She tried really hard, but could not completely quit due to her intense cravings. Toward the end of her pregnancy she had succeeded in reducing her crack use and was only smoking marijuana. The Ministry of Children and Families had not been involved until after she
gave birth at the hospital. Linda’s newborn was tested positive for marijuana. The child was not apprehended; instead both mother and child were sent to the BC Women’s Hospital Fir Square Program for two weeks. Linda brought her child home and unfortunately began using again. Linda was in a treatment centre with her one child, fighting hard to escape her addiction.

4.2.4 Carly

Carly angrily recalls how she hated her parents. She remembers her dad coming home one evening and telling her she was an embarrassment to the family and belting her over and over again. Carly still does not understand why. Carly grew up amongst physical and emotional abuse. Carly was apprehended, and protected from this abuse, yet she cries talking about the pain she still carries with her to this day. At the age of 13, Carly was introduced to crystal methamphetamine, which she used for the next five years, during which time she again became a victim of domestic violence. She states that her boyfriend broke her nose, would throw things at her and would punch her in the back of the head so no one could see the cuts and bruises. Carly refrained from using crystal methamphetamine and turned to alcohol for comfort. At the age of 19, Carly became pregnant, at which time she completely stopped drinking, but continued to smoke pot. She also left her abusive partner who had continued to beat her while she was pregnant. After she gave birth to her child, Carly indicates living alone and becoming depressed, which lead to her relapse. She approached the hospital for help, but instead of receiving help, her child was apprehended. Carly’s parents are currently taking care of her child, while Carly works on her recovery.
4.2.5 Betty

Betty recalls a happy, yet very sheltered childhood with her two younger siblings. Betty grew up in a home with a very religious family and attended a Christian high school. Betty indicates that it was her parent’s decision that they lived without a television. Betty was married at the age of 23, to a boy from another very strict family whom she had known since she was in grade four. On their wedding day, Betty had her first sip of wine, during their wedding toast. Furthermore, it was not until after her wedding that she went to her first movie. Betty states that she felt like she missed out on a lot in her life while she was growing up.

Betty indicates she had a boring life. She was divorced after being married for 10 years. Betty had started to use “party drugs” like ecstasy, smoking pot and acid. One year after their divorce, her ex-husband passed away in an accident. Betty was distraught; she began using cocaine, and a year later, began using crack, now her drug of choice. She was nine weeks pregnant when she found out. Betty went and had an abortion she did not want a child born to a cocaine addicted mother. Two years later, she was again pregnant, but this time she did not have money for an abortion. Betty had no one to turn to; she did not know what to do. Betty completely ignored the fact that she was pregnant. She smoked crack up until the day she delivered, but during her last month, she began eating berries, worried the nutrition of the fetus. When she gave birth to her child they both tested positive for drugs. The Ministry for Children and Families became involved. Betty’s parents were very supportive during this process. Currently, Betty has legal custody of her son, but it is under the condition that her son remains in the care of his maternal grandparents at all times. Betty is in treatment where she could not bring her
child because he is less than three months old; upon the completion of her treatment the situation will be reassessed.

4.2.6 Jill

Jill grew up in a home where her parents were heavy drinkers. Jill recalls the challenges she faced while growing up; it was not easy. As a child, she recalls watching her mother being abused and then being a victim of this abuse, herself. Jill was never apprehended although her family was known to the child welfare system. Jill’s parents were using crystal methamphetamine and as a result, she began using the drug at the age of 16. Jill states that she wished she could have learned how to cope with her issues in a different way, other than turning to drugs for comfort. Jill’s use was creating a purpose in her life; her use helped to mask the pain she was feeling. Jill had been using crystal meth for four years when she became pregnant. Jill continued to use during her pregnancy, but a few months into her pregnancy she reached out for help. She connected with her youth worker with whom she had been working through the Ministry for Children and Family Development. When she became sober, she realized she did not want to use again, for the sake of her unborn child. Jill indicates that it was hard to give everything up so she continued to smoke throughout her pregnancy. Jill’s child was not apprehended, but she was monitored and supported, as needed.

4.2.7 Danielle

Danielle recalls growing up in a middle class educated family, which was unfortunately surrounded by abuse. Danielle’s father was an artist who smoked
marijuana. Her mother was a heavy drinker, whom she often feared. Danielle remembers time and time again coming home from school to a drunken mother. It was a nightmare; she would have to leave the house. Danielle ended up running away from home. She began smoking marijuana and drinking alcohol at the age of eleven. Danielle later began using ecstasy, acid and cocaine. Her mother died from alcohol use and her partner died of a heroin overdose. Danielle recalls living on social assistance and having no support system in her life. Danielle indicates altering her use, each and every time she became pregnant, but it was never good enough. She felt judged as each apprehension seemed to be based on the one before. Danielle has had five children, all of whom are in foster care.

4.2.8 Helen

Helen recalls growing up in the midst of weekly parties held by her parents in their home. She looked forward to these parties but feared the physical abuse her father inflicted on her mother, on a regular basis. Helen recollects her first time babysitting her siblings; she ended up cleaning up her mom, after her dad beat her. Helen has been using illicit drugs and drinking alcohol since she was 16 years old. Her parents are currently in the AA program, yet Helen indicates as a family they have yet to deal with their anger issues from their childhood. As a result she found herself repeating history, drinking and partying, to hide her emotions. At the age of 24, she became pregnant with twins. During this pregnancy, she smoked marijuana throughout. One of her twins died of asphyxiation while in the womb, before delivery. Helen’s other child was removed from her custody and placed in protective foster care where she could not visit her child. Helen felt hopeless; she quit counselling and began using again. Over a year ago, during her second
pregnancy, Helen used crystal meth up until two months before she gave birth. Her social worker had promised that she would have custody of her child if she quit using before she gave birth. Nevertheless, her second child was apprehended.

4.2.9 Kelly

Kelly's parents were divorced when she was only 4 months old. For this reason, while growing up, she was shipped back and forth between the two homes with a one way ticket. Kelly indicates that her mother was not a very nice lady. She preferred living with her father where there always was a party. Kelly remembers her father's home had no rules and she had no responsibilities. Although Kelly was underage, the fact that she was allowed to drink with her cousins and dad made her feel accepted. Kelly was drinking and smoking pot by the age of eleven. At the age of 20, she began using cocaine. During her first pregnancy, she was heavily into drinking and using cocaine. Her child was apprehended. Six years later, Kelly became pregnant with twins. She stopped using for a period but then relapsed 4 months into her pregnancy. Her urine test was positive for cocaine when she gave birth and as a result, her children were apprehended by child protective services. She is currently in recovery, working toward getting them back.

4.2.10 Marla

Marla recalls a life of instability and abuse. Growing up she remembers going back and forth from her mother's to her father's home and the tennis racket beatings she would receive from her father's girl friend. She felt alone with no one to protect her. Marla began using pot and acid at the age of thirteen. At the age of fifteen her best friend
committed suicide; Marla was devastated. She recalls feeling lonelier and became depressed. The drug scene became her home; she was accepted and again had friends. By the time she was eighteen years old, she was heavily involved in drugs. Marla began using heroin for the next three years. At the age of 21 she quit heroin but continued to drink heavily. When she became pregnant, Marla for the first time spilled her whole bottle of vodka down the drain. She did not want to hurt the fetus. The father of her unborn child continued to physically abuse her. Marla could no longer take it, and she left her partner. During the last trimester she was again all alone, during which time she relapsed and drank throughout the remainder of her pregnancy. Marla and Marla’s mother share custody of Marla’s daughter. Marla’s daughter is with her grandmother, while Marla completes treatment.

In summary, the women in this study were between the ages of 20 and 43. Five of the women had one child, one woman had two children, one had three children, one had four children and two had five children. None of the women were pregnant at the time of their participation in the study but all were using either alcohol and/or drugs prior to becoming pregnant. Most of these women were still trying to make sense of how their childhood contributed to their present life situation. Eight women were recovering addicts and two were active users. The period of heavy drugs or alcohol misuse ranged between four to eighteen years. Six women indicated that their drug of choice was cocaine (crack); while two preferred crystal methamphetamine and two preferred alcohol. All the women resided in the Greater Vancouver Area and lived in impoverished conditions. In addition, all of the women were either Native or Caucasian and all were English speaking.
Five women indicated that they had been physically abused by a caregiver and one woman reported additional emotional abuse. One woman was sexually assaulted by her three relatives (cousins/uncle), one witnessed her father beating her mother on a regular basis, and the two participants came from broken families where they were shipped back and forth between two homes with “no rules or responsibilities”. One woman came from a strict Christian home and reported that she had a pleasant but very confined childhood.

Seven women were raised in homes where their parents or caregivers were heavy alcohol consumers or illicit drug users. Two women disclosed that there were multiple generations of substance abuse in their family. One woman had her oldest daughter currently admitted to a drug and alcohol treatment centre.

Four women reported being placed in foster care during their childhood, and another woman’s family was known to MCFD while the children were not removed. Nine women recalled a childhood of abuse/neglect, instability, and the inability to trust the persons they relied on the most in their life. Many women indicated that their childhood memories bring forth feelings of anger and resentment, as they find themselves repeating history.

The majority of women referred to their substance misuse as a form of self medication; they used substances to help numb the pain they have carried for a long time. Some of the women indicated that this is the only coping mechanism they know. All ten women thought about and altered their drug and/or alcohol intake during their pregnancy. Two women reported an increase in their use before they could reduce their daily intake. Others used intermittently, or reduced consumption of one substance while still using
another in an effort to reduce their use. One woman quit cold turkey, relapsed, but then went right back on track for the sake of her child. Even though most of these women did not know a life without drugs and/or alcohol, they still tried and most succeeded in altering their substance use when they became pregnant. For some women, this effort to refrain from using or reducing their substance use was a first time effort.

Four women reported that their children were placed in foster care by child protection services. Three mothers had their children put in the care of their parents. Three mothers had their children with them in treatment.

4.3 Data Generation

A qualitative descriptive study (Sandelowski, 2000) of substance misusing women’s views about their needs when they are pregnant was conducted. “Qualitative descriptive studies offer a comprehensive summary of an event in the everyday terms of those events” (Sandelowski, 2000, p.336). To start, each woman was asked to answer a pre-interview questionnaire (see Appendix C). This questionnaire was used to gather some basic demographic information. I began the face-to-face audio taped interviews by thanking each participant; I acknowledged their strength in their ability to share their experience on a sensitive and difficult issue. The consent form (see Appendix D) was read to the participants and they were given the opportunity to ask me any questions before signing.

Semi-structured interviews were conducted using eight guiding questions (see Appendix E) that were modified as needed during the interview. Two examples of these questions are “To what extent did your feelings or behaviours about substance use change
when you discovered that you were pregnant?” and “What would have made it easier for you to approach/ask for help/access treatment services at the earlier stages of your pregnancy or when you first found out that you were pregnant?” Each woman was given the opportunity to participate in a debriefing session after their interview. Each participant was asked for their permission to contact them in the future for a possible follow-up interview. I had to contact two participants to seek clarification about material that was unclear during the interview. One of the two participants returned my phone call and I provided her with an opportunity to further elaborate to help me to better understand her situation, as I analyzed the data.

4.4 Analysis

Each interview was transcribed verbatim. Each transcript was content-analyzed to uncover themes. “Content analysis, focuses on the content of narratives as manifested in separate parts of the story, irrespective of the context of the complete story” (Lieblich, Tuval-Mashiach, & Zilber, 1998). Data was tentatively analyzed during the interview process and repeating ideas were noted. Tentative analysis led me to adapt my interview questions and also to fully elaborate repeating ideas. This is an important characteristic of qualitative research; “simultaneous collection and analysis of data mutually shape each other” (Sandelowski, 2000, p.338). A formal analysis took place at the completion of the interview process. Each transcript was read thoroughly. As I attempted to uncover the themes, all ideas and statements that directly addressed or related to the research question were cut and pasted onto cards. Repeated ideas were sorted into groups. “A repeating idea is an idea expressed in relevant text by two or more research participants” (Auerbach
& Silverstein, 2003, p.54). Within these recurring ideas, statements were reorganized to generate sub-themes. Finally, descriptive themes were developed that capture the needs of substance misusing pregnant women (Auerbach & Silverstein, 2003).

4.5 Validity

One of the main goals of this study was to give voice to substance misusing pregnant women. I have guaranteed authenticity by ensuring the stories I have presented reflect the meaning and lived experiences as they are perceived by the participants. I established credibility by seeking respondent validation through member checks. Member checking helps to identify any of my own biases or misunderstandings (Maxwell, 2005).

Upon completion of my data analysis, I either emailed or delivered my findings to participants, requesting their feedback. Unfortunately, I was only able to connect with three of the ten participants. The participants, with whom I was unable to connect, had either moved and/or their contact numbers were no longer in service. This likely reflects the problem of unstable living conditions.

All three women agreed that the themes identified in this study captured their needs to help foster treatment engagement. For example, Helen was quick to identify herself in the results section. Helen indicates that the results were well put together and clearly describe the needs of substance misusing pregnant. Linda, without realizing not to, took her copy of the drafted findings and proudly showed her social worker. Linda stated that her social worker has a lot of power and the purpose of showing her was to help her understand what she needed to help her to engage in treatment; Linda also wanted her social worker to understand the importance of looking at Linda in the context
of her whole situation, rather than only focusing on her deficits. Francis talked about her discharge home from treatment and how on her way home on the bus, close to where she lives, she bumped into her dealers. Francis indicates that she tried really hard to ignore them; she put on her head phones pretending to listen to music. However the dealers approached her and encouraged her to use. Francis recalls explaining herself to the dealers, but nothing worked. She took her child to her parent’s home and later relapsed; her child was apprehended. Francis agrees with the findings, indicating that long term support is necessary and until the conditions in which women live do not change, treatment cannot be completely successful. These women showed a great sense of satisfaction that someone had voiced their needs to help them to engage in treatment.

This validation has helped to ensure that my interpretation of what the participants have expressed as their personal experience is accurate. In addition, from the transcriptions I have provided verbatim quotes which were slightly cleaned up for readability purposes. The collected relevant quotes provide evidence to support my interpretations. It is important to note, that the majority of my findings represent the views of women in treatment; the views of women who did not access treatment are limited.
RESULTS

Four main themes emerged from participant stories of substance misuse during their pregnancy. Mothers reported that their treatment needs include: Collaborative Relationships with Child Protection Services (CPS), Children as Motivators for Change, Treatment with Peers and Social Context Modifications. Each of the four themes also revealed several sub themes.

5.1 Collaborative Relationships with Child Protection Services

As mothers talked about their treatment needs, their need to have a better relationship with MCFD child protection social workers was expressed consistently. Four essential components to this relationship were described: Approachability & Collaboration, Accountability & Opportunity without Judgment, Recognition of Strengths, and Consistency & Continuity.

5.1.1 Approachability & Collaboration. Eight women indicated the importance of being able to approach social workers for help without the threat of child apprehension. This fear of apprehension kept these women further away from assistance than they would like to be. Instead of acknowledging their substance misuse and being honest in requesting help, women indicated that they were more likely to hide and/or deny their problems. Helen summarized this as follows:

You hide your drug use from the Ministry because you’re scared they’re going to apprehend your baby when you-you know, you hide it and go back to it and just keep stuffing it [using drugs] and you’ve got all that shame and guilt and you
don’t want to talk to anybody and it’s fear of the Ministry apprehending your child.

As women were concealing their drug use, they further isolated themselves, even when they did not want to be alone. Women found themselves feeling threatened by child protection services. For example, as Kelly stated, “I would appreciate [CPS] not being a threat to us...because that’s—that’s pretty much what they are today as far as I am concerned, like threatening—it is very belittling—belittling, it is very stressful”. Their fear of child apprehension thus becomes another form of stress in their life at a time when they needed support to help them through an already high stress situation.

Six women identified the need for early intervention. As Kelly stated: “don’t make us feel like not good parents...try to help us...get a support worker like in earlier...start working something out while the baby’s still in the womb right?...”. Women indicate that they would easily reach out for services when they became pregnant if they felt supported rather than threatened. For example, Helen summarized the views of the women as follows:

That they’re [CPS social workers] not going to apprehend my baby right away—they were going to work with me...through it try to help me instead of you know looking down upon me and just automatically apprehending him—not giving a chance to see what um I’m capable of doing.

Women indicated that they recognized the multiple benefits of early intervention treatment, including healthier mothers with healthier children. Helen stated: “my baby probably would have been bigger—healthier weight...than what he was” if she had received support earlier in her pregnancy. Danielle talked about how her daughter’s
learning difficulties could have been less serious if she had not been afraid to trust and approach MCFD for help when she first became pregnant.

Barriers in their life have continually prevented women from accessing the help they need to further succeed in their attempts to recover. Eight women indicated that their greatest barrier has been the fear of children apprehension. For example, as Angie stated: “I was scared to go to the ministry because I knew for a fact that if I went in high or drunk they’d take my son from me. And that’s one thing I didn’t want them to do because I was doing all right for a while”. As a result of this fear, women concealed their misuse even though they wanted and needed help while they were pregnant.

5.1.2 Accountability and Opportunity without Judgment. Women needed social workers to give them “a chance” to mother, when they become pregnant and after giving birth, despite their history of substance misuse. Many women indicated that they felt judged as unfit mothers and punished when their children were removed. They indicated that they would like and felt they deserved an opportunity to prove that they can take care of their children if they have the right supports in place. Helen described this wish as follows: “I am not ready to lose my child again...I wanted them home with me”. “Give [us] a chance right? People do change...right”. Women indicated that they wanted unconditional, non-judgmental support from professional social workers, who could give them hope that change is possible. Not only did the women express the need for an opportunity to demonstrate their ability to change, but they also valued direction regarding support and resources to assist with the change process. For example, as Francis stated:
I needed the social worker to make me feel competent—like anything is possible you know, you gotta work for it...someone who is going to say um that there’s a way you know—there is hope you know and um they can point you in any direction and give you options.

Women described the importance of a social worker asking them about their current needs and then asking them how these could be best met. Danielle, for example stated that she would like a social worker to say something like this: “Let’s try and change something here...what do you need so this [a relapse] doesn’t happen?”

Women felt valued when it was clear that their opinion mattered and they were included in the decision making process, rather than being told what they need to do. Linda described this in a rather belligerent manner as follows:

People always told me that I had to get clean...saying you cant be doing this to this baby—you have to get clean and I said I know, I know and another barrier I think was, people telling me that I have to get clean...and my total attitude—I don’t have to do fuckin shit.

Being told what to do caused women to become resistant to suggestions. Instead, they indicated that they needed to be included in decisions regarding themselves.

Accountability to their social workers was identified as an important component of a Collaborative relationship. Women wanted their social workers to hold them accountable for decisions they were included in and empowered to make. For example, Francis stated how important it was that social workers “acknowledge my efforts and strength and make me stick to my commitments”. Two women stated that they appreciated their social workers’ “tough love--holding her accountable, approach”. They
felt they were given a chance, an opportunity to build a relationship with their social worker who understood that all they wanted was their children. The social worker reminded them of their goal and held them accountable for their actions. Betty summarized this as follows:

I found social services to be really helpful to me...I’ve really appreciated the help that they’ve given me, like I have a really good worker ...she was really agreeable [with what I needed] – she’s very thorough in her job, [and] I don’t mind – that she is riding my ass [holding me accountable].

Betty’s social worker helped to make a specific list of what Betty needed to do in order to achieve her goal. For example, Betty indicated that having to provide regular hair samples made it difficult “for [her] to sneak, to do drugs”. Linda had to call her social worker every morning and provide a random urine sample, when requested. When given an opportunity despite their history the women did not feel judged, but instead were able to build a supportive relationship with their social worker, who kept them accountable.

Or, as Betty stated: “It’s keeping me straight, right?”

5.1.3 Recognition of Strengths. Women repeatedly mentioned the importance of social workers recognizing their efforts and honesty as their strengths, no matter how small. Acknowledgement allowed women to feel like they were capable, and promoted self efficacy. Francis, who felt a connection with her social worker, discussed how her social worker empowered her. The social worker made sure that every decision was the client’s decision. For instance, when the time came and Francis wanted to prematurely check out of treatment, she was not forced to stay; instead her social worker reminded her that “I’d
like you to stay there for you because you said you wanted to do it”. The social worker acknowledged the participant’s efforts in this decision for her to seek treatment. Recognition of one’s strengths and the steps they have taken toward their own recovery empowers the individual and supports them in their journey to continue on improving their life. Especially since a majority of these women felt that they would be reprimanded rather than commended, if they approached MCFD for assistance.

Betty appreciated how her social worker appraised her honesty; “like I was very honest—she [my social worker] said that [being honest] is half the battle”. Many talked about the importance of needing to know “that there is support out there—[and] that they wouldn’t come and take your child if you let them know that you are addicted to drugs and alcohol—you know you would have a place where we could all sit and talk” (Helen). Women require social workers to recognize their honesty as their strength, rather than a reason to punish. Marla spoke of her experience, “I went to go get help…and social services…they took my daughter…I wasn’t too happy because I went there to get help—I didn’t go there you know to take my daughter away”. Situations such as this when a woman’s effort is unrecognized, further diminishes their ability to trust and their desire to approach MCFD social workers at a time of need. Women need to feel safe about asking for help. Marla indicates, “They need to make sure that they are not going to take away my child…and put the women through more stress than they are already in”. It has not been easy for women to ask for help because when they have done so, they have been punished. When in reality, their ability to ask for assistance is a strength these women possess and should be acknowledged as such.
5.1.4 Consistency & Continuity. Consistency and continuity of social workers was important for women, particularly when they had developed a trusting relationship with a particular worker. Women indicated that changes in staff increased stress, particularly when the approach of one worker was not consistent with the previous one. For example, as Francis stated: “They changed social workers like about five times in the whole time my kids have been in care...so that makes a big difference”. And Helen elaborated on this as follows:

You get different workers and like you just get to know a worker and then next thing you know that worker is off on a leave and then you get another worker and it is happening to us again...where we just got to know him—he’s now leaving so it is like wow...we’re going to have to meet all these other needs of another worker but we already done half of what we’ve been asked to do—it is just discouraging.

The women described the time and effort it takes to develop trust in one social worker and how discouraging it can be if the social worker leaves and they must start over. As Linda stated: “That bond that relationship and that trust that I built with her [my social worker] I’ve had to rebuild with somebody and that’s going to be really hard”. This inconsistency with different social workers had been a huge challenge for many of the women. For example, Linda described how the distress over her worker leaving caused her to relapse: “I can’t I-I use because she told me she was leaving and she was handing me—I wasn’t going to be her client anymore—I used”. Women appreciated the reality that their social workers would not be there for them forever. However, they emphasized the necessity of recognizing the stress of being abandoned by a social worker that they
trusted, given their difficulty in developing a trusting relationship and given their histories of childhood abandonment and abuse.

Follow-through from social workers was another important aspect of professional consistency and building trust. A few women talked about the many promises their workers had made with little follow-through, which resulted in women feeling as though they were not worthy of respect. Helen, for example, described how, in her view, her worker broke a promise as follows: “When I cleaned up toward the end of my pregnancy, my social worker promised me if I was clean when I gave birth to my baby he wouldn’t be apprehended...yes I was clean for 60 days and he still apprehended my baby”. Having lost trust in a particular worker, it was not easy for women to continue to engage in treatment or trust a second time; and it became that much harder for the professionals to regain it.

Altogether women would like to be able to approach social workers for assistance without feeling afraid of negative consequences such as removal of children or of being negatively judged. Women looked forward to building a relationship with social workers who were consistent in their approach, provided opportunities to demonstrate positive parenting, and who recognized their strengths.

5.2 Children as Motivators for Change

A second theme women identified was that of including children as part of recovery. Women wanted support from social workers to include their children in the recovery process rather than removing or ignoring the importance of their attachment to their children.
Nine women indicated that they gained strength from their children who became their motivation to make change. For example, as Linda stated: “There is a reason for everything...and there was a reason why I was a drug addict...there's a reason why I had a baby ...and I believe in my heart the reason I had a baby is to get me out of my drugs”. Whether it was in the context of weekend “visits” or full custody of their children, the presence of children gave women a reason to pursue recovery, a reason to not use. Marla summarized this as follows: “Yes, my child has motivated me because she’s one of the ones; I’m getting better for...because if I’m not good —she ain’t coming home”.

Children gave these women a sense of purpose which provided meaning to their lives.

Furthermore, their children fulfilled unmet needs: the need for a family, a sense of connection, a relationship and bond that many women wished they had while they were growing up. Linda elaborated on this as follows:

I think that the only things that’s going to stop me [from using]...is having a family because I never had a family that sits down at the table...and eats together and does things together—[it was] just always me alone in my room or my mom and her friends drinking—you know I never had that family life—now I have it.

Women expressed enjoyment that they have associated with motherhood. They looked forward to being clean, having a home, their kids a “normal family”, as Kelly indicates.

This is a powerful relationship; for some it even took the place of the drug. For example, as Francis stated, “Yeah he’s my rock; he’s all the rock I need”. Danielle and Angie indicated that they would currently not be using if they had some connection with their children. “I wouldn’t be using right now...if I was with her [daughter]” (Angie). Other women confirmed that they would be using if they had lost custody of their
children. Linda summarized the views of the women as follow: “Even my boyfriend said if that baby gets taken away from you that’s the end of you...you will die...as a junkie...you will die as a junkie...that’s the end of the story...and I truly believe that in my heart”. Women currently in treatment with their baby indicated that they are receiving the help they need, and have decided to no longer use because of their child.

For these reasons, five women expressed the need for treatment that allows their children to accompany them. Linda elaborated, “I really believe that um you shouldn’t exclude your kids from your recovery—your kids are the most powerful asset in your recovery...I truly believe that...”. The majority of women agree that treatment that does not incorporate their children becomes a barrier; and some indicated they would have not accepted treatment if they were not allowed to bring their children with them. Treatment with children is very beneficial; the mother and child form a bond and grow together. Betty summarized this as follows: “The longer [I] have, that [I] remain sober, and the more time I spend with my son, the more reason I have to stay clean and [have] more strength...the main motivating thing is taking care of [my son]”. It is not to say that these women all of a sudden never thought of using, but that their children gave them a reason not to use. Jill explains, “While I was pregnant with him I...thought of well when I have him maybe I can use again—whatever right? Once he was out I was like no way I can’t do that...things changed right?”

Francis indicated that she worked hard to get her children back, and she succeeded. But she recalled, “I went from two hour visits twice a week to full time four kids (laughing) and that was like whoa [overwhelming]...so I ended up going back to my addiction—they were apprehended [again]...”. Step by step support is necessary; women
who became pregnant while they are using recognized that they wanted to make a change in their life; however, they cannot proceed with this change all alone.

In circumstances where the child had been apprehended, women expressed the importance of not losing connection with their children. Helen described what was needed: “encouragement from the Ministry where I would be able to see my son on the weekends or something—but they said I was not allowed to see him at all”. The visits would have given her a reason to work toward not using. Jill stated, “I think like even if [she is] still using, still have supervised visits just don’t completely cut her off from seeing her child, you know because that’s not right—the child should be able to know who their mom is still, you know”. Women did not want their children to feel abandoned, rather to know that mom still cares and that she is working hard to improve her health, so she can be the mother they need.

Children are a form of strength which provided motivation and represented family. Substance misusing women are affirming that when they became pregnant, for the first time in their life they want to make a change. Women emphasized that they needed their social workers to support them with this change by including their children in their treatment plan, rather than removing them.

5.3 Treatment with Peers

Seven women expressed that treatment for substance misusing pregnant women needs to include women who are or have faced similar life challenges. Mothers feel less shame and guilt when speaking with other women who are in comparable positions. Helen elaborates this as follows, “You know having other people that you know you
could talk to, [who are] in the same situation would be easier and [just]...knowing that they’re not look[ing] down upon you...” cause your pregnant and struggling with an addiction (p.8). Sharing feelings with women who are going through something similar can normalize the experience, rather than it being something “different” or “unfamiliar”. This creates a sense of safety and friendship. Carly describes a place where “[you can] really see that...people do care about you, you can make friends, people will reach out to you, people will hug you when you’re sad and will love you until you love yourself...right? That will be a cool program”. A group with their peers would represent another form of strength and reassurance that they are not alone.

Furthermore, six women indicated having recovered women, who had misused alcohol and/or illicit drugs during their pregnancy lead groups of women who are currently facing similar challenges would be very beneficial. Linda stated, “Hearing how bad their lives were...and look[ing] at where they are now...[as] some kind of role model...yeah, it is really helpful to see, that you know everybody has their own situation but we can do it [recover]”. Learning that change is possible, even under the worst conditions, is very empowering. Not only is this approach beneficial for struggling substance misusing pregnant women, it would also provide an opportunity for those who have recovered to feel valued as they share, teach and give to those women who continue to struggle today. Carly summarizes this as follows:

A lot of women that are sober-you know that have sober time behind them should be starting it [group]...It would make them feel important—make them feel like they’re doing something...I’ve had really crappy jobs in my life...I’ve never really felt like I’ve amounted to anything or really helped anyone and doing
something like that would be...you’re helping the community—you’re reaching out to women that are just like you and I think it would be a great thing to do.

Women also talked about the importance of providing opportunities to recovered women; to not only teach struggling women in a group setting but also to counsel women individually. Danielle indicates, “[we] need counsellors—need counsellors that have already been through it—don’t let them have requirements...that you’ve got to have grade 12, this, that and the other thing, no, because it’s life experience”. Women have expressed the value of life experience over “book smarts”. They want to learn from other women who were using when they became pregnant; they truly feel these women can relate and genuinely understand. Women need role models to support them to help break the cycle of addiction. Danielle elaborates,

Let women learn how to be counsellors and give them a good pay to go to school and teach people how to do it...because baby—we’re going to have a future race if this isn’t stopped—this dysfunction—of children being screwed up...I mean and that’s got to stop...it is got to stop now...it should have stopped 10-20 years ago you know and now we’ve got this race or this new group of people who all have FAS and cognitive [and] other problems and stuff like that—it is got to stop...I am just a woman trying to get through life everyday but thinking about it I wouldn’t want a young woman going through the same stuff I went through as a young woman when I was having children...

Women require role models who truly understand the challenges they have faced with their addiction and pregnancy who will not judge them but work with them toward their goals.
5.4 Social Context Modifications

Finally, several women said that treatment for substance misusing pregnant women needs to consider the women within the context of their lives, rather than the addiction alone. This includes a practical and mental health component.

5.4.1 Practical Needs. Housing, transportation, support services under one roof, and education were the four practical needs repeatedly mentioned as a component to treatment for substance misusing pregnant women.

Seven of the ten women did not have a stable living environment at the time of their last pregnancy. When women did not have the necessities for healthy living, their environments became very stressful and things were further complicated with their pregnancy. Angie recalls, “we were homeless...we were living on the streets... [my partner] he’d go for days without eating to make sure I ate – made sure the baby got enough”. Linda indicates that for the “first half of my pregnancy I was basically living in a crack house”. Having a supportive living environment, away from the addiction, further helped these women to make the changes they often initiate when they became pregnant.

Transportation is another important practical need. Most women recalled feeling unwell while using during their pregnancy. This made it difficult for women to get to treatment even if they wanted to. Therefore, the need for transportation to help women get to treatment became essential. Kelly recalls how this really helped her, “I was very sick all the time [during my pregnancy], you know she [a worker] actually came and picked me up right at my door”. Transportation assisted women to engage and continue with accessing support, when it would have been easier to shut the door and stay home.
Living under their current conditions, becoming pregnant, and then having to go to multiple sites for services can be very discouraging and becomes an additional source of stress, especially when transportation is not available. The majority of women agreed that services should be ideally at one location and provided on a long-term basis; this would also decrease the need for transportation to and from the multiple service sites. Danielle summarized the views of the women as follows, “there should be lots of programs [support]...both while pregnant and post partum”; ongoing support is necessary. This gives woman an opportunity to seek support not only before the birth of their child, but also when their child is born. Carly indicates, “What I have to do everyday to feel sane is go to meetings or I’m constantly thinking of drinking”. This support can slowly begin to take the place of the alcohol and/or drug use.

According to the women, an educational component that addressed the multiple issues in their lives is also considered essential in treatment. They wanted to know more about their options, learn more about healthy pregnancy and parenting. Angie summarized the view of the women as follows: women needed to know “how to look after themselves...[to]make sure they eat properly and get enough sleep...not only for them but for the development of the baby”. Learning about issues such as breast feeding and nutrition were significant. Danielle indicates that without the practical necessities, such as “...proper food...a better place to live [life is] oh God...just an awful experience”.

Education about harm reduction techniques was also requested. Betty indicated that all substance misusing women may not be able to quit using while pregnant;
therefore, it was very important to provide education to women on harm reduction techniques. Betty elaborates as follows:

“There’s all these different myths running about what’s worse or what’s better, if you are thinking about damage...it is good for pregnant people to know the [facts], if you are going to smoke crack while you are pregnant...is it more harmful to your fetus to smoke it on brillo, on copper, on stainless steel brillo or on ash or cooked in ammonia or baking soda...like does one do more damage than the other like—those are all the things [that] there’s no information about...[this is] something to think about for harm reduction.

Therefore, if not all woman under these circumstances can or want to quit using alcohol or drugs while pregnant, at least with this education women can work toward reducing harm and give children a better chance at life.

5.4.2 Mental Health Needs. Majority of women have been using alcohol and/or illicit drugs for various reasons; their use is often a coping mechanism or a form of self medication. It is very important that these women have the opportunity to seek treatment that helps to reveal the purpose that drug or alcohol serves in their life. For some women, drugs and alcohol had always been a way of life; Helen indicates “my disease—it’s hereditary from my parents-and they’ve done drugs and alcohol too, and its monkey see, monkey do...I was brought up with it for 12 years” (Helen, 2007, p.2). Women stressed the importance of one to one counselling; Helen elaborates on this need to know:

To understand why they’re doing this and feeling this way—maybe they could get some help from a counselor to understand the way they were brought up and to
help them in ways of change right? Change their belief system, [from] oh it was okay daddy got drunk and hit us with the belt ...change that...like let them know that [it] was the wrong thing to do and help them with different beliefs and stuff right?

Currently, women are understandably overwhelmed while using when they become pregnant. Their pregnancy becomes another source of anxiety alongside the existing stressors. Women continued to struggle with challenges that have never been dealt with from their childhood. Angie recalls, “...I am still having trauma from childhood”. Most women have hid their childhood pain in their addiction, as a means of coping. The way the women felt stemmed from their experience in childhood.

Seven women, in their adulthood were being honest when indicating that they cannot attend to their struggles alone; they need the help of the professional social workers to help them address the multiple issues that have stemmed from their childhood and are being carried forward into their future. Danielle explains why;

These people [MCFD] are making my life miserable because they weren’t giving me the help that I needed. They weren’t giving me the treatment that I needed and I needed to go into treatment...and deal with my crack issues...and deal with grief and loss issues...and all these freaking issues...that I had going on...and I was left out in the cold to deal with all this shit...by myself.

Women wanted the long-term support of social workers to help access treatment that incorporates their past and current struggles; Dawnya summarized the views of women as follows: we need “counselling for a couple years...we need somewhere where we can be during our whole pregnancy”. Helen elaborates, “we needed...places like treatment
centres—the funding for that and the courage to go there...encouragement from the social workers and it would have been a lot easier not to do drugs”. Most women wanted an opportunity to talk about the real underlying issues that few would discuss because of their fears. Issues that are not dealt with from their childhood are perpetuating a cycle and haunting these women in their adulthood. Carly elaborates:

We never talk about [the] abuse by our significant others...and we never talk about our drug use while we’re pregnant because nobody wants to talk about that because they’ll shun you-[that]is how you feel—[so] that’s not on the topic...like oh yeah, I used this when I was pregnant and I kept using all throughout my pregnancy and drinking my face off...it blows my mind but it is not who they are...it was their escape route and you know if they talked about it and get it out you know, they don’t need to go back to that shit...and they could start over and know what it is like to live clean so...

It is not until these issues of childhood trauma, grief and addiction are dealt with that these women can move forward and work toward breaking this generational cycle. For example as Jaime stated, when it came to the real underlying issues, “we never talk about those [underlying] kinds of issues”. Women acknowledged that it has not been easy to resurface their histories of abuse and/or pain; however, they realize that this is necessary in order to heal. Marla indicates, “Now I have to deal with the pain...at first it is hell, [but now] it is helping...because I am getting everything out...”. Women wanted to address their pain, become self aware and get in touch with who they are. When this occurs, healing can begin and this will be a huge step toward their recovery. Women
wanted the support and guidance of social workers who understood them beyond their addiction.

Altogether, these themes and sub themes represent what substance misusing pregnant women said they need to help them to engage in treatment. Treatment for substance misusing pregnant women, according to the women themselves, cannot be complete until recovery includes the women in the context of their life circumstances, opportunity for better relationships with social workers and treatment with their children, their peers and among positive role models.
6 DISCUSSION AND CONCLUSIONS

Women in this study were able to clearly and articulately indicate the components of treatment that would aid in their recovery. Specifically, the themes elicited from their stories indicated that they valued Collaborative Relationships with Child Protection Services, Children as Motivators for Change, Treatment with Peers, and Social Context Modifications. These themes are consistent with and indicate a general support for the women-centred (gender specific) harm reduction model of treatment. This model acknowledges that women are motivated to make positive changes in their life when they become pregnant. Therefore their pregnancies become an ideal opportunity for social workers to support them toward healthy change (Kershner & Paltrow, 2001).

When substance misusing women become pregnant, they face a dilemma. The birth, or impending birth, of a new child serves as a strong motivator to eliminate or reduce substance misuse, but at the same time, the threat of punitive responses from service agencies serves as a barrier to seeking help (Poole & Isaac, 2001). Specifically, fear that their child will be apprehended and that their custody rights may be altogether negated can serve to keep women away from approaching appropriate services (Lester et al., 2004). Women in this study, however, indicated that they would be more willing to approach services if they were assured that the nature of the services would be collaborative, that they would not be separated from their children, that treatment would occur together with a peer group, and that treatment would address the multiple social issues they face.
6.1 Collaborative Relationships with Child Protection Services

Child protection social workers have potentially conflicting mandates of parental support and child protection when dealing with substance abusing pregnant women. Swift (1995) indicates that a contradiction "exists between authority and the helping function proposed by social work" (p.160). Contradictory role expectations of CPS social workers often conflict and impede the most effective service being provided. Women in the present study indicated contact with CPS is regarded as threatening given the punitive nature of past interactions. The reality is that these women are subject to surveillance by CPS before and once their children are born, regardless of the suggested response. Therefore, when CPS are offering both antenatal supportive and postnatal child protection services it becomes difficult for some women to believe that support can be provided without the threat of child removal. As a result, CPS struggle to engage and provide the required support to substance misusing pregnant.

Alternative CPS responses to pregnant substance misusing women have been developed. For example, MCFD CPS—Fraser Region Operating Policies and Procedures, policy # 2006-03 OP suggests that social workers offer support services to substance misusing pregnant women rather than immediately flagging women for a future child protection report. This policy indicates that social workers need to clarify to women that their role as a child protection social worker is different than their interest to provide these women with the support they need. However, even when CPS are offering alternative responses or providing important support services to substance misusing pregnant women, women are reluctant and continue to fear the power that social workers hold in their child protection role. This continues to be an enormous barrier in getting
women to engage in treatment. As the women in this study indicated, they need and want help but whether or not CPS is the best resource to offer them this support is questionable.

A suggested resolution to this dilemma might be that CPS work collaboratively with other less intimidating services to develop conjoint services that can reach out to women without the immediate threat of apprehension. It would be important to ask women who are not seeking treatment which service agency or in which treatment context they would feel safe. For example given the role of public health in promoting prenatal care, would they feel safe approaching public health? Using this example, CPS could oversee, fund and assist public health outreach social workers/nurses (who would need to be familiar with the women's social context) to implement women-centred harm reduction prenatal support services for those who have become pregnant while misusing substances. The hope would be that support provided through a multidisciplinary approach other than child protection would assist substance misusing pregnant women to alleviate their fears around social work involvement and children apprehension. This available support could build on their motivation to make positive changes in their life while pregnant. Less intimidating services could provide supportive services without a child removal mandate and CPS social workers would intervene as needed, post birth to protect children and/or to assist women access treatment with their new born children. Overall, the role of CPS antenatal-birth may need to be more in the background, monitoring progress and assisting in securing resources rather than actively investigating.
6.2 Children as Motivators for Change

Previous research has documented that women typically are reluctant to access services, particularly residential treatment services when they cannot have their children by their side (Lester et al., 2004). Removal of children and foster placement is often not ideal (Field, 2000) since foster parents are frequently unable to provide prenatally exposed babies required care so resources for these children remain limited. Multiple placements frequently ensue (Lester et al., 2004). Furthermore, child apprehension is a traumatic experience for both mother and her child (Kershaw & Paltrow, 2001). Mothers, not surprisingly, therefore tend to avoid any possible threat of child apprehension, even when this involves sacrificing their own desire and need for treatment.

As mothers in this study demonstrated, their children represented a major motivator for change. Professionals therefore need to understand that children may play an important role in the mother's recovery process. Nonjudgmental professional support can provide women with an opportunity to demonstrate their ability to parent. Allowing women to bring their children to a treatment facility that also includes child-care also provides them with this opportunity.

Treatment should be an ongoing, long term process that attends to the distinct and shifting needs of substance misusing pregnant women and post birth, to her role as a mother (Lester et al., 2004). The women centred harm reduction model is based on the belief that when substance misusing women become pregnant and then mothers, it is an ideal opportunity for professionals to support these women and help to build on their motivation toward healthy change (Kershner & Paltrow, 2001).
An example of a treatment facility that includes children is Peardonville House Treatment Centre (Abbotsford) the only program in British Columbia that provides residential support to substance misusing women and their children. This is a 10 week program for women 19 years or older. Women are encouraged to bring their children to treatment; however, children younger than three months of age are not allowed to accompany their mothers (Peardonville House Treatment Centre, 2006). More of such residential treatment services for substance misusing pregnant women are required. However, it would be beneficial if women were able to bring their children with them to treatment, post birth from hospital, even if their child is less than three months of age.

The first three months are critical; mother and child are building a bond through attachment. However, when children are less than three months of age, demands of the baby are high; babies are up every few hours as their routine is not yet set. Women will need increased supports at this time to help them to attend to their children, build attachment and to also be actively involved in treatment. An example of a program available to mothers at and after the time of birth is British Columbia Women’s Hospital Fir Square Combined Care Unit. This unit has 11 beds for both antepartum and postpartum care, for pregnant women who want to stabilize or withdraw from their alcohol or drug use. Fir Square’s multidisciplinary team provides support, counselling and education to the women. During their pregnancies women are required to go to mandatory parenting and alcohol/drug counselling classes. After they have given birth, women return with their babies to the Fir Square Unit. Nursing staff spends time teaching mothers about breastfeeding, caring for a newborn, parenting and learning the signs and symptoms of their baby’s possible withdrawal. According to Fir Square they observed
that when mother’s breastfed and have more skin to skin contact through cuddling, and had their baby with them in the same room, their child’s withdrawal symptoms were decreased and there was less need for pharmacological treatment (Payne, 2007). Also, this post birth interactive process between mother and child is critical to help the two emotionally bond and build an attachment (Sears, 2007). This attachment is an essential relationship that becomes the foundation on which the newborn’s future relationships and personalities are formed (LaFreniere, 1998). This women centred harm reduction care model within an acute-care setting obviously has many benefits. Fir Square at BC Women’s Hospital has demonstrated that both mother and baby benefit when they are together after delivery. Therefore an increase in budget to enhance the numbers of available beds as well as trained staff, who can adequately help care for newborn children, is necessary.

6.3 Treatment with Peers

Women in this study indicated their preference for connecting with other women who are struggling with similar challenges of substance misuse and pregnancy. Also, they indicated desire to connect with women who have overcome these challenges and are now on their road to recovery and who can become their mentors.

This finding supports a consistent theme in the literature that gender-specific treatments that include peer support are confirmed as effective (Poole & Isaac, 2001; Russell & Gockel, 2005; Lester et al., 2004). Mentorship/peer groups are beneficial to pregnant substance misusing women. These programs provide mutual support that allows women to understand their use. Also they encourage women to share their
experiences/strengths while working together toward the various ways of healing (Poole & Isaac, 2001).

One way to have peer and mentor support is through a group program supported by a residential treatment centre. This type of group provides an opportunity for sharing amongst other women who are struggling with substance misuse issues, while pregnant. This sharing gives women strength as it becomes a form of reassurance that they are not alone. It also provides a sense of connection and responsibility for the well being of others in the group. Women feel safe sharing personal and difficult issues with other women who can personally relate and understand. This support and mentoring empowers women by affirming that change is possible.

While peer support is desirable it is questionable whether peer support alone is adequate to support women with multiple social problems. For example, Alcoholics Anonymous is based on a peer-driven mentorship model without any professional involvement. For women, such as the ones in this study with traumatic childhood histories, peer support alone can be limited. The women centred approach includes an ongoing peer and mentorship component to connect women who are struggling or have struggles with similar challenges, but it also incorporates and acknowledges the value of professional support. The combination of peer and professional support therefore provides maximal benefit.

6.4 Social Context Modifications

The fourth theme elicited in this study was treatment that included modifications of the generally impoverished social context. This included provision of both practical
and mental health assistance. This finding supports other research that recommends empowering women through providing practical supports like transportation, housing, parenting supports, child care and mental health services (Finkelstein, 1994; Poole and Isaac, 2001).

As the women in this study indicated, substance misusing pregnant women frequently have multiple layers of need, including change of the social conditions in which they live. Too often, women are discharged from residential treatment to the same living conditions from which they came (Weaver, 2003). Support is therefore required in terms of provision of adequate financial means, finding more appropriate housing, establishing new relationships that do not involve substance abuse and an opportunity to deal with childhood histories of trauma.

Also, as demonstrated in this study and in accord with previous studies, many women use alcohol and/or drugs as a coping mechanism or a form of self medication due to the multiple issues stemming from their childhood (Zelvin, 1999; Rutman, Jackson & Field, 2000) such as parental substance abuse, sexual abuse, physical abuse, psychological abuse, residential instability and familial mental health issues (Marcellus & Kerns, 2007; Cosden, 1997; Finkelstein, 1994; Howell et al., 1999). One suggestion for dealing with these multiple issues has been a multidisciplinary comprehensive treatment program based on a women centered harm reduction model where all services are available under one roof, a “one stop” type model (Poole & Isaac, 2001, p.27). This treatment program would not only address the practical and mental health needs of the mother, but would address the needs of the child and the family unit. The importance of incorporating mental health and practical needs of mothers within the child protection
context has been previously noted (Farmer, 2000). It has been suggested that when the
multiple problems faced by mothers are addressed, outcomes for children who are born
into these social contexts will also significantly improve (Kershner & Paltrow, 2001).
Therefore, child protection services would remain a separate entity but a range of all
other support services would be incorporated and integrated, preferably in one location.

An example of such a program that provides many services in one location is the
Sheway Project in Downtown Vancouver, which according to Poole & Isaac (2001) has
achieved great success in engaging substance misusing pregnant women. Another such
program is the Breaking the Cycle (BTC) in Toronto that also uses a “one-stop” model
for service delivery to high risk substance misusing pregnant women and their families
(Dell & Roberts, 2005). Such a “one stop” model within a residential treatment facility
would be ideal. Essential residential programming would include parenting programs that
incorporate children, education and job skills training. Over the long term these programs
would assist women to integrate into the work force and help them find stable housing
before they are discharged from treatment. Also, the program could include both one to
one counselling with professionals as well as group therapy with other peers and mentors
who have faced similar challenges.

6.5 Protecting those Children that Need Protection

This study is not by any means saying that every substance misusing mother is
wanting or capable of taking care of their children after they have given birth. There will
be cases where children will need to be apprehended for the best interest of both mother
and child. What needs to be recognized is that child apprehension is a traumatic
experience for both mother and her child (Kershner & Paltrow, 2001). Therefore, if it is still deemed necessary to remove a child after a thorough strength based assessment that provides women with support, CPS social workers need to address the traumatic nature of apprehension with the child and the mother. Trauma support services should be mandatory. We cannot give up on these mothers, but continue to try and engage them in treatment. Children need to know that they did not do anything wrong. They need love and support to help understand their mother’s circumstances. Also the idea of visitations should not be discarded. Those who do not receive an opportunity to heal from such trauma continue to carry this pain with them for the rest of their lives. As a result, generations continue to suffer; too often these children grow up using alcohol or illicit drugs as a means of coping.

6.6 Limitations

Qualitative research is not predictive like quantitative research. The strength of this research is that it provides an in-depth understanding of the treatment needs of substance misusing pregnant women. The majority of the women in this study were from a suburban setting, while two women were from the downtown eastside (DTES). These findings of this study, therefore, can only be considered suggestive of the problems women face in DTES.

Also, eight of the women interviewed were in a treatment setting and therefore the findings largely reflect women who have successfully engaged in treatment. Therefore, again the study is only suggestive of the views of those women who are not in treatment.
However, themes identified in the present study were endorsed by the two women who were not in a treatment setting as well as the women who were in a treatment setting.

Another limitation to current findings is that the majority of women interviewed were single mothers, and therefore findings do not reflect the needs of women in committed relationships. In addition, all of the women interviewed were of a lower socioeconomic status so that views of women at higher socioeconomic levels are not reflected.

The women in the present study, with one exception, all reported having had traumatic childhoods. While this may be commonplace among women struggling with problematic substance use, it may also limit findings to those women with such histories.

Also this is a one-sided story, in that the focus is on pregnant women and not MCFD social workers. This study is strictly from the substance misusing mother’s perspective. However, this was done intentionally because women’s stories are often not heard.

6.7 Future Direction

It would be informative to explore the views of front line social workers who work with substance misusing pregnant women regarding their social work approach. Although one study by Weaver (2007), explored the views of social workers working with substance misusing mothers, there is still a gap in the literature considering the growing medical and social concerns. Also it would be important to study middle or upper class women and compare how their stories resonate or do not resonate with the single poor women’s stories. Another area of interesting research could include, studying
fathers, ethnic minorities or disabled single mothers to look at how their stories do or do not resonate with the experiences reported by women in this study. Lastly, conducting research in the area of prescription drugs and pregnancy would be very valuable.

6.8 Conclusion

In conclusion, three major findings with corresponding treatment recommendations have been presented. First, pregnant women who have a history with child protection are less likely to trust child protection inasmuch as they are likely to have a heightened concern regarding child apprehension. Secondly, pregnant women with a history of drug and alcohol abuse want support throughout their pregnancy. Thirdly, pregnant women with a history of drug and alcohol use may be less likely to continue to use drug and/or alcohol throughout their pregnancy if support services were available.

Even though many women expressed concern about MCFD, all wanted to have a better relationship with MCFD CPS workers. A better relationship was defined as non-judgmental, strength based, collaborative and accountable. As well, women saw their children as key to their recovery. The children acted to motivate the women as they worked through their issues related to drug and alcohol abuse. In addition, women expressed a desire to be involved in peer related treatment. Having other women who had dealt with similar experiences share in treatment made sense to these women. Finally, women saw the need for integrated treatment, which addressed all areas of need, as opposed to focusing on drug and alcohol misuse in isolation.

There are a number of treatment recommendations that flow from the findings. The first recommendation is that there is a need for more preventative programming and
education programming for women. This includes providing all young women prior to their childbearing age with the facts on the dangers of misusing substances while pregnant. During pregnancy, women require information regarding abstinence from alcohol or illicit drugs (Lester et al., 2004). Furthermore, prevention efforts need to include education that encompasses not only illicit drugs but also licit drugs, including prescription drugs. The impact of preventative programming has been shown to reduce long term health and social costs as well as long term consequences for these young mothers, their children, and society in general.

As well, it is recommended that child protection review and resolve the inherent contradiction between strength based preventative programming and deficit based child protection. This inherent contradiction often proved difficult for social work professionals who appear to be trying to implement a mixed message. If it is difficult for the professional social worker it must serve as a bigger challenge for the client. In the end, the client will usually be impacted by the negative message as opposed to the positive message. Also, substance misusing women who are coming to the attention of social services are often poor. Class and ethnic issues needs to be taken into consideration when assessing risk factors in relation to child development. Especially since "...the greatest impediment to cognitive development in children is not drug use, but poverty (Lester, Boukydis, and Twomey, 2000, cited in Marcellus, 2007, p.35). Furthermore, child protection has to come to terms with the contradiction of child protection working with both the mother and the child. A problem is that there will be times when the interest of these two parties will conflict and the worker will be required to enforce the child protection mandate. Developing policies must be fair and whenever possible a separate
worker should be assigned to the mother and child. There also needs to be a universal approach that indicates specific criteria for mothers or children who should be screened for licit and illicit drug and/or alcohol exposure. There should also be universal guidelines for reporting to child protection services, guidelines for child removal from parental care and guidelines for seeking permanent alternative placement (Lester et al., 2004). For example, is drug use alone enough to warrant a report to CPS or should there have to be evidence of abuse or neglect as a sufficient reason to report to CPS? Furthermore consulting women and then implementing treatment services they would feel are less threatening and more appropriate in terms of meeting the needs of the substance misusing pregnant women, while child protection workers continues to safeguard the needs of the children. Finally, on the long-term, agencies should try as much as possible to provide services at one site. Services could include drug and alcohol support services, opportunities for women to establish new relationships, one to one counselling to deal with childhood histories of trauma, a means to finding appropriate housing and employment.

In closing my opinion is best captured by Boyd (2007) “if we are truly interested in fetal health, birth outcomes and family stability, we need to encourage women to seek services” (p.27). In addition, we can easily encourage substance misusing pregnant women to “seek services” once we acknowledge their motivation to make healthy changes and after the supports they need to help them to engage in treatment are made available. Therefore we need services that women can seek which are effective and accessible.
References


*Child, Family and Community Service Act.* (1996). Queens Printer: Victoria, BC


Appendix C

Pre-interview Contact Questionnaire

1. Name:__________________________
2. Age:_______
3. Address:_______________________________________
4. Phone Number:_____________________
5. Marital Status:_____________________
6. Children:_____
7. Drug of choice:_____________________
8. How long have you been using:_____________________

Appendix E

Interview Protocol

Time of interview:
Date:
Place:
Interviewee:

Briefly Describe the Study...

Research Question: From the perspective of women themselves, what aspects of intervention do substance misusing pregnant women identify as fostering treatment engagement?

Interview Questions

1) Tell me about your drug (or alcohol) use in your life?

2) To what extent did your feelings or behaviours about substance use change when you discovered that you were pregnant?

3) When you first found out that you were pregnant what were your main needs? Were these addressed? How/Why not?

4) What helped in getting your needs addressed?

5) What hindered in getting your needs addressed?

6) What would have been the pros and cons of accessing treatment services at the time you found out that you were pregnant?

7) What would have made it easier for you to approach/ask for help/access treatment services at the earlier stages of your pregnancy or when you first found out that you were pregnant?

8) What in your opinion are the main components of an effective service for pregnant women who are (struggling with use) using drugs and/or alcohol?
**CERTIFICATE OF APPROVAL - FULL BOARD**

**PRINCIPAL INVESTIGATOR:** Mary Russell  
**INSTITUTION / DEPARTMENT:** UBC/Arts/Social Work & Family Studies  
**UBC BREB NUMBER:** H06-03647

**INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:**

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<th>Site</th>
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<tbody>
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Other locations where the research will be conducted:
Women will be recruited from the Vancouver Area Network of Drug Users (VANDU), from Options: Services to Communities Society and from Peardonville House Treatment Centre. These women will be interviewed at a time and place most convenient for them (i.e. their place of residence). However they will not be interviewed in a public space to ensure that others do not overhear our conversation.

**CO-INVESTIGATOR(S):**  
Parveeri Bahga

**SPONSORING AGENCIES:**  
N/A

**PROJECT TITLE:** The Core Components of an Early Intervention Treatment Approach as Perceived by Substance Misusing Pregnant Women.

**REB MEETING DATE:** December 19, 2006  
**CERTIFICATE EXPIRY DATE:** December 19, 2007

**DOCUMENTS INCLUDED IN THIS APPROVAL:**

<table>
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<tr>
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<tr>
<td>Advertisements: Recruitment Poster</td>
<td>November 20, 2006</td>
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<tr>
<td>Questionnaire, Questionnaire Cover Letter, Tests:</td>
<td>November 20, 2006</td>
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<tr>
<td>Interview Protocol</td>
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<tr>
<td>Pre-Interview Questionnaire</td>
<td>November 20, 2006</td>
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<td>November 18, 2006</td>
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The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval is issued on behalf of the Behavioural Research Ethics Board and signed electronically by one of the following:

- Dr. Peter Suedfeld, Chair  
- Dr. Jim Rupert, Associate Chair  
- Dr. Arminee Kazanjian, Associate Chair  
- Dr. M. Judith Lynam, Associate Chair

https://rise.ubc.ca/rise/Doc/0/NFC4DGSUS064330ES7169KTM77/fromString.html  
1/29/2007