Mothering and Substance Use: Approaches to Prevention, Harm Reduction, and Treatment

In 2009 a national virtual Community of Practice (vCoP) provided the opportunity for a “virtual discussion” of issues, research, and programming related to girls’ and women’s substance use in Canada. The goal of the vCoP was to serve as a mechanism for “gendering” the National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada. Participants included planners, decision-makers, direct service providers, educators, NGO leaders, policy analysts, researchers, and interested women. The project was sponsored by the British Columbia Centre of Excellence for Women’s Health (BCCEWH) in partnership with the Canadian Centre on Substance Abuse (CCSA) and the Universities of Saskatchewan and South Australia.

This discussion guide highlights one of the topics explored in the vCoP. Its purpose is to stimulate further conversation on addressing the needs of pregnant women and mothers in substance use prevention, harm reduction, treatment, service system planning, and policy making.
Gendering the National Framework

Background

Mothers and pregnant women with substance use problems face multiple barriers in accessing support and treatment services. Fuelled by misinformation about women’s substance use and addiction, and harsh media representations, stigma and judgement are ever-present in women’s support networks, service delivery, and program policies. Although there are welcoming and mother-centred programs across Canada, there are vast gaps in the availability and accessibility of these services, depending on the required level of care, mothering status, and the severity of health and social problems.

Due to fears of disclosure and limited data, it is difficult to quantify how many mothers and pregnant women have substance use problems. According to the 2001 Canadian Community Health Survey, 12% to 14% of women reported that they had used alcohol in their last pregnancy. [1] A recent American survey of pregnant women reported that 19% of women used alcohol in their first trimester, 7.8% in their second trimester, and 6.2% in their third trimester. [2] Further, of the women who used alcohol in their first trimester, 8% binge drank, 21.8% smoked cigarettes, and 4.6% used marijuana. [2] Particularly concerning was the rapid resumption in binge drinking from 1% in the third trimester to 10% within three months postpartum. [2]

It is estimated that 18% of mothers engaged with the child welfare system have alcohol problems, and 14% have other substance use problems. [3] It is also documented that First Nations mothers in Canada lose custody of their children more than non-First Nations women; First Nations children are placed in care at a rate of 1 in 10, whereas non-Aboriginal children are placed in care at a rate of 1 in 200. [4]

Given the risks of heavy substance use to both women’s and children’s health, including the risk of Fetal Alcohol Spectrum Disorder, it is imperative that a continuum of gender-informed services be available to mothers and pregnant women with substance use problems.

Participants in the virtual Community of Practice (vCoP) discussed four topics related to mothers and pregnant women with substance use problems: 1) stigma and public discourse, 2) barriers to treatment, 3) a guiding framework for practice, and 4) examples of Canadian mother-centred programming. An overview of these four topics is presented here, followed by a list of discussion questions and a list of weblinks, both which emerged from this vCoP. The discussion questions are designed to facilitate the application of a gender-based analysis to addictions prevention, harm reduction, and treatment programming and policy as they relate to pregnant women and mothers.

Stigma and public discourse

Stigma surrounding women who are pregnant or mothering and using substances is evident throughout our systems of care and in the public discourse. Historically, and presently, public discourse has been both blaming and unsympathetic towards mothers who use substances. [5] Further, mothers who use substances are deemed solely responsible for their circumstances, and undeserving of care. [6] Despite national efforts to shift this paradigm [7], media continue to misrepresent the needs and intentions of mothers with substance use problems, and propose punitive, over supportive, health-
oriented responses. [8, 9] Consequently, shame and fear of prejudicial treatment based on motherhood status are ever-present, and prevent women with substance use problems from accessing the care that they need and deserve. [10]

Barriers

Barriers for mothers and pregnant women with substance use problems are evident on three levels: systemic, program, and personal/social. [11] At a systems level, barriers are created in punitive mothering policies, fragmented services, and narrow service mandates. The needs of women and children are often polarized, and linked and combined support for the mother-child unit is overlooked. [5] Women repeatedly report that fear of losing their children is one of the most significant barriers to treatment. [10, 12] When women do access treatment, silos of services with narrow mandates can result in women being turned away due to the complexity of their situations; situations that intertwine, for example, substance use in combination with violence and trauma, mental ill health, physical health problems, and housing needs.

At a program level, admission criteria and wait lists are common barriers. For example, some programs require a certain number of days abstinent before a woman is eligible for support. This may not be a realistic criteria given inadequate housing and challenges in meeting basic needs. Wait lists may make it difficult for mothers to retain custody of their children, and the timing of child welfare requirements and substance use treatment services are often out of sync. [13] Other program level barriers include service hours, location (urban vs. rural), and cultural appropriateness.

On a personal level, women may not be supported by their family and peers, and they may be afraid to leave their children in the care of others. In some instances, pregnant women are living with violent partners who do not want them to make changes to their substance use. [14] Until treatment services understand many of the personal and social barriers faced by mothers, and take active steps to reflect this in their service delivery, women will continue to be faced with decisions such as choosing between treatment and caring for their families.

Guiding framework for practice

It is important that practice, programs, and policies be principle-based and firmly grounded in evidence. The guiding framework underlying effective treatment and support for mothers and pregnant women with substance use problems, which gained support in the ActNow BC Healthy Choices in Pregnancy initiative (www.hcip-bc.org), includes being mother/women-centred, harm reduction oriented, and taking a collaborative approach to treatment. [15, 16]

Mother/Women-Centred

Historically, society and health care services have taken a child- or fetus-centred approach in their response to substance exposure in pregnancy, with little regard to the health and well-being of birth mothers. [17] Women-centred care offers an alternative by focusing on the mother-child unit. Emphasis is placed on the woman’s own health pre, during, and post-pregnancy and internal motivation for change is supported. Within this framework, the negative social responses to women who are pregnant or mothering and have substance use problems are acknowledged, and service providers assist women in dealing with stigma, punishment, and blame. [18]

Harm reduction oriented

In the context of mothering and pregnancy, reducing the harm of substance use often means attending to women’s basic needs such as nutrition and housing. Harm reduction approaches take a pragmatic and compassionate approach to care. Service providers are willing to discuss goals other than complete abstinence from all substances (in spite of the known risks), and consider all aspects of harm. [19] In this approach, there is recognition of the interconnectedness of many areas of women’s lives, such as trauma, mental ill health, and substance use. [20, 21] Accordingly, engagement in treatment begins with what is most important and possible for the woman.

Collaborative

Collaboration is a key principle of both women-centred and harm reduction approaches. It is critical to successful relationships with women, and change and healing happen in supportive, non-judgemental, respectful relationships. [22-24] In collaborative approaches, women are viewed as the experts on their own lives and work collaboratively with service providers toward paced, achievable, change.

Motivational interviewing (MI) is an evidence-based communication style that supports engagement and is noted to improve the health of women with substance use problems and related concerns, particularly in the childbearing years. [25-27] MI combines relational components with key skills and strategies [28], thereby guiding change while at the same time supporting collaboration, empowerment, and respect for autonomy.
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Examples of Canadian Mother-Centred Programs

While a generic range of treatment services are available to mothers, these services are not always visible or readily accessible. [29] The National Treatment Strategy offers recommendations to strengthen available substance use services and support through five tiers of support and treatment. The tiers are described as:

Tier 5 - Intensive residential treatment
Tier 4 - Structured and specialized outpatient services
Tier 3 - Acute, proactive outreach and harm reduction services
Tier 2 - Brief support and referral by a wide range of professionals
Tier 1 - Community-based and outreach services

(For a more detailed description of the tiers see: www.nationalframework-cadrenational.ca/uploads/files/TWS_Treatment/nts-report-eng.pdf)

To successfully address the needs of mothers and pregnant women with substance use problems, we need gender-informed programming and practices that reflect the guiding framework in all 5 tiers of support and treatment. The following Canadian examples demonstrate the types of programming and practices needed at each tier of support and treatment.

Tier 5 – Residential treatment programs

There are very few Canadian examples of residential treatment programs that accommodate mothers with their children. However, in an attempt to address this limitation of services, some jurisdictions are putting in place supportive housing options, with links to residential treatment, for pregnant women prior to delivery, and new mothers and their infants postpartum.

Tier 4 – Structured outpatient services

Jean Tweed Centre, Pathways to Healthy Families and MK2, Toronto, ON
(www.jeantweed.com)

The Pathways to Healthy Families project, initiated in 2002, addresses the need for building capacity within the system to better identify and serve women who use substances who are pregnant or mothering young children. It involves the placement of substance use counsellors in satellite sites across Toronto, including community health centres, resource centres for young parents, the shelter system, and Aboriginal services. These counsellors provide education and support services to women and their children, as well as to agencies. The focus of the support is to connect women with local resources, advocate on their behalf, and link them with parenting and medical care. [30]
Arising out of the Pathways to Healthy Families project, Mothers and Kids Too (MK2) is a specialized outpatient program that addresses the needs of mothers who are pregnant and/or who have children under the age of six. MK2 is a seven week long, three day a week, format that provides both substance abuse counselling and parenting support. In this model, women do not have to choose between their family and treatment. Emphasis is placed on integrating programming for parents and children, ultimately supporting early childhood development and engagement of parents.

**Tier 3 – Proactive outreach and harm reduction services**

**Pregnancy Outreach Programs (Canada Prenatal Nutrition Program)**

Community-based pregnancy outreach programs (POP) funded across Canada through the Canada Prenatal Nutrition Program (CPNP) offer drop-in, multi-faceted, prenatal and postnatal programming to support the overall health of mothers and their children. Attending to basic needs such as nutrition, physical health, and safety, POPs work pragmatically to meet women where they are at and to reduce the harms of substance use. In many instances, women with substance use problems may feel safer accessing services through POPs than asking specifically for addiction treatment services and risk losing their children.

There are approximately 350 CPNP projects serving over 2,000 communities across Canada, and over 550 CPNP projects in Inuit and on-reserve First Nation communities.

**Tier 2 – Brief support and referral by a wide range of professionals**

**Brief Intervention by Physicians**

Physicians play an important role in both recognizing and engaging mothers and pregnant women with substance use problems, and they play a pivotal role in the prevention of FASD. 

Given the social stigma and misunderstanding of this health problem, it is critical that health care providers are able to ask about substance use in a supportive and non-judgemental way.

The PRIMA (Pregnancy-Related Issues in the Management of Addictions) project assists physicians in providing care for pregnant and postpartum women with substance use problems through continuing education initiatives and web-based resources on the effects of various substances and clinical considerations (www.addictionpregnancy.ca).

Physician education has been offered nationally through a continuing education course on Fetal Alcohol Spectrum Disorder created by MDCme.ca, a consortium of seventeen Canadian medical schools and the College of Family Physicians of Canada (www.mdcme.ca). This curriculum is currently being updated.

Several provinces have also undertaken educational initiatives with physicians: for example the ActNow BC Healthy Choices in Pregnancy initiative worked with physicians to implement provincial guidelines on screening and discussing alcohol with pregnant women (www.hcip-bc.org/resources-for-practice/physicianresources.htm); and Ontario’s Best Start has developed desk references and related tools for physicians (www.beststart.org/resources/alc_reduction/index.html).

**Tier 1 – Community-based and outreach services**

**InSight: Mentor, Support, Empower, Manitoba**
(www.gov.mb.ca/healthychild/fasd/insight.html)

The InSight Mentoring Program is a Manitoba-based example of one of a number of peer support mentoring programs evolving across Canada. It is a voluntary intensive case management program that provides service to women who are pregnant or recently gave birth, and have used alcohol and/or drugs heavily. Mentors provide intensive one-to-one support for women and their families for up to 3 years. The focus is on reducing barriers and building safe, collaborative relationships that empower women in making paced, achievable, changes.
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Discussion questions

The following questions are intended to support direct-service providers, program leaders, and system planners in reflection on their current practices, policies, and procedures.

1. What have you noticed about how mothers and pregnant women with substance use problems are treated within the health and social service system? What do you notice about your own reactions?

2. Consider your program, practice, and/or policies from the perspective of a mother with a substance use problem who needs help. How will you be welcomed? What sort of questions will you be asked? How will it feel talking with a service provider who potentially has the power to impact your ability to mother (i.e., remove custody of your children)? What would make this safer?

3. What can you do in your role to shift media and societal perceptions of mothers and pregnant women with substance use problems?

4. How is your program linking with other agencies in a position to support women's health and reduce harms related to substance use? How is your program supporting women to connect within their communities?

5. What can be done to improve the relationship with the child welfare system to best support the mother-child unit?

6. What steps are being taken to integrate childcare services with current programming?

7. What opportunities are there for staff education for learning practice skills such as motivational interviewing? How does your work environment support ongoing learning and sustainability? How are the outcomes being measured?

8. How are mothers and pregnant women with substance use problems involved in influencing program development specific to your service?

Weblinks

National
Fetal Alcohol Spectrum Disorder (FASD) Prevention: Canadian Perspectives (Public Health Agency of Canada)
This document describes a four-part model for approaching Fetal Alcohol Spectrum Disorder prevention from a women's health perspective. It is a practical resource that shares the wisdom of program providers across Canada and offers examples of promising practices in action.

Motherisk
www.motherisk.org
Motherisk offers information and counselling to pregnant and breastfeeding women, their families, and service providers, on a number of topics, such as the impact of licit and illicit substance use in pregnancy. The website hosts a variety of written materials and lists toll-free helplines, including the Alcohol and Substance Use Helpline for information about the fetal effects of alcohol, nicotine, and drugs like marijuana, cocaine, and ecstasy (1.877.327.4636).

Provincial
Alberta Health Services, AADAC Effects Series
www.aadac.com/547_1430.asp
This series is designed to give women specific information about the health effects of various drugs, with a special focus on how drug use may affect pregnancy, birth, and child development. The information is presented in a non-threatening, women-centred way moving from the health of the mother to the health of the fetus.

Best Start
www.beststart.org
This Ontario-based resource centre has developed a variety of materials and tools to support service providers working on health promotion initiatives to improve the overall health of women and their children. Print resources are available for order on topics such as pre-conception health, alcohol and pregnancy, and post-partum depression.

Coalescing on Women and Substance Use
www.coalescing-vc.org
This website highlights online “virtual” discussions on six key topics related to women’s substance use in Canada including mothering and substance use, and the prevention of Fetal Alcohol Spectrum Disorder. The site also offers a number of helpful information sheets highlighting key points and resources related to each of the six topics.

Healthy Choices in Pregnancy
www.hcip-bc.org
This website hosts a number of resources to support service providers, researchers, and system planners in their work related to women and alcohol and related health issues. Recent publications, past presentations, webcast recordings, and resources for women around the health impacts of alcohol are all available on this site.
Summary

This discussion guide was prepared to assist individuals and agencies working on the National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances with the application of gender-based analysis. Hopefully it will be a useful resource in the development of “gender-informed” prevention programming, harm reduction initiatives and treatment directed to mothers and pregnant women, by those working on the Framework, and by others interested in improving policy and practice related to substance use and addiction in Canada.

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