



SUBSTANCE USE DURING PREGNANCY

AN OVERVIEW OF KEY CANADIAN POLICY AND PRACTICE AREAS

BACKGROUND

In Canada, many people are asking questions about how best to support pregnant women who use alcohol and drugs during pregnancy so that they and their babies can have a healthy and safe start in life.

Accessing health care and social supports prenatally is an important factor in improving maternal and infant outcomes. Without prenatal care, women who struggle to abstain from using substances during pregnancy are more likely to miscarry, give birth prematurely and have infants with low birth weights, with symptoms of withdrawal or with alcohol and drug related birth defects and developmental disabilities (1). They are also more likely to have their children removed from their care (1-2). Thus, it is in the best interests of both women and their infants if they are able to access appropriate care and treatment during pregnancy.

Legislation, social policy and health care and child welfare practices can contribute significantly to effective care and support for women who use substances during pregnancy. This backgrounder provides a brief overview of several important areas of policy-making and discusses how policy can contribute to developing supportive health and social services to effectively address substance use during pregnancy.

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ADDICTION TREATMENT POLICY AND PREGNANT WOMEN



Improving Access to Care and Treatment

Women who are pregnant and who struggle with substance use often report a range of barriers to accessing available supports and resources, including stigma and judgment from health care providers, lack of childcare limiting their ability to participate or attend treatment, limited financial resources, lack of transportation, and limited family or social support (1-7). As well, women who are pregnant often find it difficult to access treatment and care that addresses both addiction concerns and prenatal care (8-11). In response, many provinces have developed policies to improve access to addiction treatment for pregnant women. These policies include giving pregnant women priority access to addiction treatment programs for the general population, providing treatment programs specifically for pregnant women and providing treatment programs for new mothers and their infants.

Research suggests that treatment and support options for pregnant women with substance use concerns should include a combination of the following (3, 8, 12):

- Prenatal care
- Nutritional support
- Withdrawal management
- Addiction treatment
- Supportive maternity care and NICU
- Housing options
- Family and parenting support
- Advocacy and outreach

Voluntary versus Mandatory Addiction Treatment for Pregnant Women

In Canada, a pregnant woman cannot be mandated by a court order to attend addiction treatment when her fetus may be in danger of harm resulting from substance use. This reflects numerous ethical and legal issues related to the right to refuse medical treatment, informed consent, reproductive rights and social responsibility for the fetus.

In Canada, the question of whether a woman legally owes a “duty of care” to her fetus went before the Supreme Court in 1996 (14). “Ms G,” a 23-year-old First Nations woman from Winnipeg, was ordered into treatment by the court when five months pregnant with her fourth child due to concerns about glue sniffing. Although the original ruling was overturned by the Manitoba Court of Appeal and “Ms G” decided to get treatment of her own accord, Winnipeg Child and Family Services took the case to the Supreme Court. Seven out of 9 Supreme Court Judges concluded that the court does not have the right to force pregnant women who have substance use problems into treatment programs.

Some of the issues raised during the case in support of this decision included (15):

1. Research in the addiction field demonstrating that forced treatment can be ineffective (16).
2. Many pregnant women who misuse substances already avoid accessing health care services due to fear that their children will be removed from their care. As a result, they are driven “underground” and deprived of necessary care. Forced treatment laws would be counterproductive in increasing access to treatment.
3. Concerns about forced treatment laws being applied unfairly, i.e., to women are poor and/or members of racial minorities.
4. Awareness that this type of legal response does not address the systemic and social causes of substance use including issues such as violence, sexual abuse, and poverty.
5. If fetuses were to be granted a legal right to care, the court could extend the power to institute control over any behaviour in all women of child-bearing age.

Criminalization of Substance Use during Pregnancy

In Canada, there are no laws specific to substance use during pregnancy. In the United States, only the state of Tennessee has passed legislation specifically criminalizing drug use during pregnancy. However, prosecutors in other states have used other criminal and civil laws (such as child abuse or neglect allegations or laws concerning exposure of a child to a chemical substance) to prosecute pregnant women who use substances (17). As a result, women have been arrested, incarcerated in jails and prisons, been detained in hospitals, mental institutions and treatment programs, or had their parental rights terminated.

Research has shown that these arrests and detentions have not resulted in prompt or appropriate treatment and care and are a violation of the constitutional rights of pregnant women (18-19). As well, these measures are viewed by medical and public health groups as counter-productive as they deter women from seeking prenatal care, accessing addictions treatment or speaking openly about their alcohol and drug use with health and social service providers. Recently, in the United Kingdom, a case heard by the upper tribunal of the Criminal Injuries Compensation Authority has raised questions about whether a child can seek legal compensation from his or her mother for alcohol consumption during pregnancy. The outcome of this case also may have implications for women who use alcohol and drugs during pregnancy (20).

Alcohol and Tobacco: “The Legal Drugs”

While illicit drug use during pregnancy tends to receive greater media and public attention, research over the past two decades has consistently shown that tobacco and alcohol (“the legal drugs”) are the ones that can cause the most harm during pregnancy (13).

MATERNAL HEALTH CARE POLICY



Screening and Brief Interventions by Health Care Providers

National guidelines have been developed to encourage health care providers to ask women about alcohol and drug use during pregnancy and as part of overall primary care (21-23). There are a number of sex-specific screening tools available for clinical use, some of which have been validated for use during pregnancy (22, 24). The use of Motivational Interviewing techniques, online and telephone support, as well as peer or lay mentoring programs by paraprofessionals are other approaches which have been shown to be effective in creating opportunities for discussing and sharing information about alcohol and drug use during pregnancy (25-30).

Policy can be critical in creating clinical environments in which screening and brief interventions by health care providers are effective. Strong arguments exist against routine urine drug testing, mandatory reporting to child protection services of suspected alcohol or drug use during pregnancy, and meconium screening immediately following birth. These approaches can create an environment of scrutiny and mistrust which may result in women being less likely to disclose alcohol use to their health care providers or to disengage from prenatal care (31-32). Health care providers may also find that these policies create a number of ethical challenges and interfere with the provision of high-quality care (22).

Clinical guidelines, developed by organizations such as the Society of Obstetricians and Gynecologists of Canada, support health care providers in addressing substance use with women in the perinatal period.

Child Welfare Reporting Requirements By Health Care Providers

Numerous studies have shown that the fear of child welfare involvement and having their children removed from their care is one of the greatest barriers for pregnant women when considering accessing addiction treatment and prenatal care (1-3, 9, 15, 17, 34). Health care providers do not have a legal obligation to make a report about prenatal substance use. In many jurisdictions, policies and protocols have been developed to use the prenatal period as an opportunity to build relationships with women and to organize the provision of treatment and support services that will make it more likely for women to be able to parent their newborn.

In some situations where it is likely that a health care provider will be required to make a report to child protection services after birth, women have been encouraged to contact child welfare services on their own prior to birth. Some women with addiction issues will be able to parent successfully with appropriate support. In situations where women are unable to care for their children on their own, their involvement in decision-making around options such as partial custody, kinship and elder support, placement with extended family, or open adoption can lead to better outcomes (35-36).

Meconium Testing

Meconium is the first stool from an infant and is composed of materials ingested while in utero. When tested following birth, meconium testing can provide information about prenatal exposure to alcohol and drugs in the second and third trimester of pregnancy.

Some researchers have advocated for the routine use of meconium testing as not all women are forthcoming with information about their substance use when asked by health care providers. Advocates suggest that meconium testing can provide opportunities for early intervention and follow-up services.

However, meconium testing has raised numerous ethical issues, including concerns about targeted vs. universal screening (targeted screening can be potentially stigmatizing), a lack of available follow-up services in the event of positive screening, ensuring informed consent by mothers, undermining of trust by women in her health care providers, and respect for women's autonomy (31, 33).



CHILD WELFARE POLICY AND PRACTICE

Maternal Substance Use and Child Safety

The mandate of child welfare services is to ensure the safety and well-being of children where it is believed that a child is at risk of maltreatment or where maltreatment has been identified. The child welfare system includes family support workers, child protection workers who provide assessment and intervention, judges, lawyers, and other government officials. A significant portion of families involved, or at risk for involvement, in the child welfare system are impacted by parental substance use problems. However, not all parents who have problems with substance use maltreat their children. Parenting skills, positive parent-child relationships, financial and other resources, and the availability of other practices related to confidentiality and information sharing, collaboration with addiction treatment and other health and social care caregivers are all factors known to mediate the potential negative effects of parental substance use problems.

Child welfare policies and practices can greatly affect outcomes for new mothers with substance use concerns and their children. In many families where maternal substance use occurs, the proactive provision of supports and services that focus on strengthening families can ensure both the well-being of children and their mothers. Policies and services, the use of strengths-based models in assessment and planning (e.g., the international Signs of Safety initiative), initiatives to support practice improvements and training in specialized issues, and transparency about situations requiring child removal, are just a few of the areas that can make a difference.



As well, involving mothers who are not able to care for their children in decision-making about the placement of their children and, when appropriate and possible, supporting women in reunifying or retaining a role in their children's lives can lead to improved outcomes for all.

Prenatal substance use, on its own, is not an indicator of parenting ability.

Integrated Programs and Cross-sectoral Partnerships

Evidence suggests that integrated programs for pregnant women with substance use concerns are effective in reducing maternal substance use, improving maternal mental health, fostering use of prenatal care and favourable birth outcomes, and enhancing parenting skills. Many of these programs foster opportunities for positive engagement with child welfare services prior to birth (9).

Pregnant women with substance use concerns may have encounters with a number of health and social services, including anti-violence organizations, mental health and addiction services, primary care, parenting, family support and life skills development programs, and social housing. A lack of collaboration between these services and child welfare services can have negative outcomes in terms of engagement with prenatal care, participation and completion of addiction treatment, healthy mother-child relationships, and providing women with the practical resources to successfully care for their children. Barriers to collaboration include different definitions of who the "client" is (e.g., the parent vs. the child), different attitudes and levels of awareness about addiction, different agency mandates, lack of leadership, and the perceived costs of cross-sectoral collaboration.

Evaluation studies support models and approaches of collaborative practice that involve partnership with child welfare services (9, 34, 37). In many provinces, there have been initiatives such as the development of practice guidelines to guide collaboration between substance use treatment centers and child welfare agencies, cross-sectoral staff training (e.g., between child welfare and anti-violence organizations), and the use of communities of practice to foster dialogue and guide system change.

MOVING AHEAD – IMPROVING POLICY AND PRACTICE

There are a number of policies and practices that contribute to effective care and support for pregnant women with substance use concerns. These include policies where:

- Pregnant women are given priority access in general addiction treatment programs
- Addiction treatment programs have been developed and are available specifically for pregnant women
- Addiction treatment programs specifically for new mothers and their infants are available
- Protocol(s) exist between child welfare and the substance use field on collaborative practice across fields

While formal policies and protocols are important, these policies are not always reflected in practice due to system capacity issues. For example, many regions have priority access to treatment for pregnant women as a policy, but few actual beds, which inhibits the ability to enact this commitment. There are also provincial and regional (urban-surburban-rural) differences in service

availability and other barriers to equitable and accessible service delivery (38).

This overview has outlined the current status of policy and substance use treatment relevant to substance use in pregnancy. We need to continue to discuss, and to act to expand upon promising responses in policy and service delivery that can support women's health and prevent the short and long term effects of prenatal substance exposure for their children. It will be important to improve and coordinate the policy responses in all three areas identified here: in, addictions treatment, maternal health care and child welfare practice.

RESOURCES

Websites

Canada FASD Research Network
www.canfasd.ca

Canadian Drug Policy Coalition
www.drugpolicy.ca

FASD and Child Welfare Community of Practice
www.fasdchildwelfare.ca

National Advocates for Pregnant Women (USA)
www.advocatesforpregnantwomen.org

PRIMA (Pregnancy-Related Issues in the Management of Addictions)
www.addictionpregnancy.ca

Information Sheets and Policy Guidelines

Alcohol, Pregnancy and Prevention of Fetal Alcohol Spectrum Disorder: What Men Can Do to Help, 2014
Canada FASD Research Network
www.canfasd.ca

Clinical Practice Guidelines: Substance Use in Pregnancy, Society of Obstetricians and Gynecologists of Canada, 2011
<http://sogc.org/guidelines/substance-use-in-pregnancy>

Roles and Responsibilities of the Director (Child, Family and Community Service Act) and the Ministry Of Health: For Collaborative Practice Relating to Pregnant Women At-Risk and Infants At-Risk in Vulnerable Families: Protocol Agreement, Government of British Columbia, 2013
www.health.gov.bc.ca/women-and-children/pdf/973472-ProtocolAgreement-Mar27-signed.pdf

Mothers and the Substance Use Treatment System (Information sheet)
BC Centre of Excellence for Women's Health, 2007
www.coalescing-vc.org/virtualLearning/section2/documents/MotheringandSubstanceUse-infosheet3.pdf

Practice Guidelines between Toronto Substance Abuse Treatment Agencies and Children's Aid Societies Practice Guidelines Working Group, 2005
http://www.camh.ca/en/education/Documents/www.camh.net/education/Resources_communities_organizations/Practice%20Guidelines%20Substance%20Abuse%20and%20Child%20Welfare.pdf

Preventing FASD and FAS: Working with pregnant women who use substances (Information sheet)
Alberta Health Services, 2010
<http://fasd.alberta.ca/documents/hi-asa-women-info-prevent-fasd.pdf>

Structural Interventions in Child Welfare (Information Sheet), First Nations Child and Family Caring Society of Canada, 2013
http://www.fncaresociety.com/sites/default/files/Information%20Sheet%20_%20Structural%20Interventions%20in%20Child%20Welfare.pdf

Supporting Pregnant and Parenting Women Who Use Substances: What Communities Are Doing to Help
Canada FASD Research Network, 2012
www.canfasd.ca

Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers
US Department of Health and Human Services, 2005
<http://store.samhsa.gov/product/Understanding-Substance-Abuse-and-Facilitating-Recovery/SMA05-3981>

This policy overview was developed by members of the Canada FASD Research Network's Action Team on FASD Prevention from a Women's Health Determinants Perspective.

To learn more about our work, visit www.canfasd.ca.



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