Mother and Child Reunion:
Achieving Balance in Policies Affecting Substance-using Mothers &
Their Children

Nancy Poole (BC Centre of Excellence for Women’s Health)
Lorraine Greaves (BC Centre of Excellence for Women’s Health & UBC)

KEYWORDS: PREGNANCY, MOTHERS, SUBSTANCE USE, ADDICTIONS, CHILD
PROTECTION, MEDIA DISCOURSE, POLICY, VALUES-BASED POLICY

This paper describes a policy framework aimed at ensuring that the interests of substance-using mothers and their children be linked, in tandem with an analysis of urban mother’s words describing their interpretations of policy in this realm. This framework and the mothers’ testimony have been used in cities across British Columbia (BC) in professional education with health, social service, and child welfare professionals working with pregnant women and mothers who use substances, and in virtual communities of practice involving child protection and substance-use workers. This article describes the responses of providers in these two educational contexts and assesses the ongoing utility of the policy framework. A more balanced public policy regarding mothering and substance use is unlikely to evolve without leadership at the system planning level that empowers practitioners to be flexible in recognizing both women’s and children’s interests.

This article advances a values-based approach to addressing mothering and substance use. The values-based approach uses values, rather than risk assessment, as a base for guiding policy and practice in this area. We first describe how, in 2002, we derived a values-based policy framework based on discourse analysis of media and policy documents about mothering and substance use, and set it beside the words of mothers who have experienced the effects of those policies in their own lives. Then we describe two settings, one provincial and one national, in which this material has been recently used in professional training and knowledge translation. We describe the responses of practitioners and policy makers to the framework, and identify the barriers to its implementation. We argue that without systemic leadership that validates the linked interests of mothers and children in the current legislative context, practice changes that more sensitively and overtly include both mothers’ and children’s rights and considerations are unlikely to develop.

Over three-quarters of all Canadian women report they drink alcohol (Ahmad, Poole & Dell, 2007). The rates, patterns and frequency of drinking vary by age, education, marital status and rural/urban location. Urban women report higher rates of light frequent drinking and lower rates of heavy frequent drinking than women from rural locations (Ahmad et al., in press). Yet over the past decade, as we have become more aware of urban women’s patterns of alcohol and other substance use through survey research, increased evidence has also emerged of the impact

1 Nancy Poole would like to acknowledge doctoral fellowship trainee support from IMPART, A Strategic Training Program on Gender Women and Addictions (www.addictionsresearchtraining.ca/) and NEXUS, Researching the Social Contexts of Health Behaviour (www.nexus.ubc.ca/). The British Columbia Centre of Excellence for Women’s Health and its activities and products have been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent those of Health Canada. For inquiries, please contact Nancy Poole, BC. Centre of Excellence for Women’s Health, 4500 Oak Street, E311 Box 48, Vancouver, BC. V6H 3N1. E-mail: npoole@cw.bc.ca
of drinking even moderate amounts on women’s health and on fetal development (Dell & Roberts, 2006). Still today, on this important women’s health issue, conflicting messages on the safety of alcohol use in pregnancy abound (Join Together, October 11, 2007). Research and accurate health messaging on other substance use by pregnant women and mothers remains scarce and often women receive inadequate, uninformed or prejudicial support from health care providers and social workers in a position to provide treatment (Boyd, 2006; CAMH, 2008). It is time for evidence from research, practice, policy implementation, and the lived experience of mothers to inform health promotion approaches to women’s alcohol and other substance use, particularly in the context of pregnancy and mothering. Yet advocates for Canadian women have been increasingly concerned about the reduced importance of women in policy discussions and decision-making about mothering, particularly in situations where a fetus, infant, or child is exposed to risks to their health or safety (Boyd, 2004; Poole, 2001; Status of Women Canada, 2000). Media and policy discourses often reflect a child-centered focus that constructs children’s interests as competing with or subsuming the interests of mothers (Boyd & Marcellus, 2007; Campbell, 2000; Gomez, 1997; Greaves et al., 2002; Humphries, 1999). This focus can effectively reduce or even, in some circumstances, override women’s rights.

In each province in Canada, a mix of federal and provincial legislation and policy affects pregnant women and mothers with substance-use problems. In federal documents such as the Divorce Act, and in provincial documents such as BC’s Family Relations Act and Child, Family and Community Service Act and their related implementation documents, the best interests of the child are enshrined. It’s significant that a child’s entitlement “to be protected from abuse, neglect, and harm or threat of harm” (Child, Family and Community Service Act, Section 1.2) is often achieved in practice by imposing limitations on the mother, rather than by enhancing the mother’s health, safety, and capacity to parent. In fact, implicit throughout these documents is the theme of competing rights and interests — between parents in the case of child custody and access, and between the parent and child in the case of child protection.

**Identifying the Discourse About Mothering & Substance Use**

In 2001, we undertook a discourse analysis of media and policy documents, and we used publicly available stories of substance-using mothers in conflict with the authorities, to provoke discussion among a group of urban women in the Downtown Eastside of Vancouver who had had direct experience with these policies. We noticed how media and policy discourses are in a constant dialogue with each other and with public attitudes and views, and how in fact a web of discourses affects mothers who use substances or have addictions (Greaves et al., 2004; Greaves et al., 2002).

We collected media examples from two national newspapers and a Vancouver-based newspaper over a one-year period. We examined policy documents from the province of BC, and we had group discussions with women in downtown Vancouver. Nonetheless, many of the issues raised and the documents considered reflect wider attitudes and interests. In addition, many of the news items reflecting judicial decisions that were part of the media analysis originated in other countries, particularly the US, but they became part of the discourse in Canada. In both Canada and the US, multiple levels of jurisdiction (from institutional and municipal supports to national and international policy) and many different sources of data (from international media to local critical incidents) affect the discourse on mothering. These materials illustrate how the situations of substance-using mothers in Canada affect how we talk, think, and write about mothering, and how the resulting discourses interrelate and affect the evolution of policy and public attitudes.

We analyzed this material utilizing the concepts of ‘rights, risk, and evidence’ to focus on if and how rights of mothers and children were constructed in the materials, how risk was measured and assessed (in narrow and positivist or in contextualized and co-constructed ways), and what types and sources of evidence were used. We were also interested in if and how
women’s experiences were solicited, interpreted, and treated. Throughout, we asked how evidence was being employed and how the concepts of risk and rights affected the discourses on mothering under duress.

A key conclusion of our analysis was that a woman’s responsibility for using substances while mothering was seen to rest with her, i.e., her actions were seen as deliberate and within her control. This reflects the negative view of women who use substances while pregnant (Greaves & Poole, 2005). The discourse in news reports related to substance-using mothers was, on the whole, judgmental, punitive, and unsympathetic. The analysis of the media materials also assessed the responsibility of the social, treatment, or legal systems. The articles rarely made reference to the system(s) in a position to support women with substance-use problems, and did not articulate a systemic responsibility for assisting women with harm reduction or recovery. Women were portrayed as ‘worthy’ and ‘unworthy’ depending upon the degree to which they were deemed responsible for their circumstances. Substance users were generally deemed unworthy of help because they were portrayed as responsible for their fate through their ‘willful’ actions. In fact, anger toward women who used substances was evident. Most of the news articles in the original study and in ongoing coverage appear to blame the mothers for the situation and express little or no optimism about chances for change and successful mothering (Greaves et al., 2004; Moneo, 2007).

What did the Mothers Say?

The urban mothers who had been using substances were interviewed in focus group settings. The discussion was guided by scenarios that were based on three public stories related to key incidents in Canadian cities in which women using substances and/or their children have come in conflict with the law, child welfare authorities, or a coroner. One was about a woman who had been taken to court by her ex-partner to make her agree to not smoke in a car with her son, before she was able to take him on a car trip. The second story resulted in a provincial inquiry: it was about a woman who had died of a drug overdose while her child was in her care. The third was about a pregnant woman addicted to solvents whom a child welfare agency took into custody and confined to treatment against her will on the basis of owing a duty of care to her fetus, and whose case became the subject of an appeal to the Supreme Court of Canada.

The discussions reflected women’s direct experience with systems and policies, and showed how deeply institutional, policy and media discourses affected these women. We identified four major themes in the women’s conversations. The women spoke of ‘bad mothers,’ ‘good mothers,’ ‘thwarted mothers,’ and ‘addicted mothers’ in their reflections on the three scenarios (Reid, Greaves & Poole, 2008). Underpinning all four of these conversational themes was a view of (themselves and) other women as morally worthy human beings who deserved consideration and respect. At times the women’s discourses reflected dominant discourses that placed the rights of mothers and their children in opposition, while at other times the discourses focused on the rights and health of the child and how these could be best supported through supporting the mother-child bond (Reid, Greaves & Poole, 2008).

The women’s accounts revealed various inter-connected systems of support and control, as well as the ways in which women themselves, service providers, and the public may reproduce the perspectives of ‘the best interests of the child’ that dominate policy and media discourses. Each set of circumstances was associated with a distinct set of challenges that individual mothers had to experience and negotiate, but there were some common elements. Mothers reflected negatively on being perceived as a “case” in which their challenges and concerns were decontextualized from their lives and treated with standard bureaucratic surveillance and scrutiny. This approach often exacerbated their duress. They also argued that wider factors were omitted from the consideration of risk and evidence, such as whether or not they were on the road to recovery, or whether or not they had arranged their own support systems to help. The women reported losing control over their lives and often felt punished by the systems. Finally, though the women rarely discussed this, it was impossible to ignore the impact of poverty on
their mothering experiences, which was critical in getting help, reducing stress, and offering material supports to their children.

Women were very aware of how their pregnancy and motherhood represented either a risk or a redemptive possibility. But as substance-using women, they were also aware that they put themselves at risk of increased scrutiny about pregnancy and mothering if they access treatment. Indeed, Poole and Isaac (2001) found that a key barrier for mothers seeking treatment is the fear that they will lose custody of their children on the sole basis of having a substance-use problem. The reactive nature of the system was commented on many times by women in our study who emphasized the need for ongoing financial and social supports to maintain wellness and the custody of their children. As one woman noted:

Apprehending the infant does something to the bonding, too. Because what happened to me with my son… he means the world to me, but there’s still something missing. Because I didn’t have him right from when he was born, he was taken away from me when he was born, but after I got him back, it still felt like there was something missing. Like I admit to myself and to everyone here that I am a sick person and I need help. And when I didn’t have this safety and stuff… I was voicing this to the ministry workers who used that information against me, and I was no harm to my children, I was seeking education, was seeking counselling, was trying to fix all these things and keep us together as a family unit, so that my children could see the recovery in process and what a healthy world is supposed to look like. When they break you up and shove you here and there and everywhere else, it adds more stress and trauma to those children’s lives, you know.

While feeling like a ‘case’ could be demoralizing, there were a few instances when context was taken into account and women felt that good decisions were made and support was given. But overall, the almost complete lack of focus on the mother-child bond, and the negative and permanent results of this inattention, was the most salient theme. The impact and consequences of policy were obvious and central to the responses of the women. The short-term effects demonstrated in the stories of the women who had suffered from the intergenerational effects of government policy. For example, financial supports were often available to foster parents, but not to the mothers, resulting in mother-child separation, when decreasing the financial hardship on some mothers may have allowed them to maintain their children and themselves in healthier ways. Mothers also described demoralizing hurdles, such as repeated changes in the criteria for having their children returned to them following their participation in addictions treatment, which made it more difficult for them to maintain their health and recovery.

From the focus groups with mothers, along with the media and policy analysis, a detailed picture emerges of the web of discourses about mothering under duress. The web of discourses indicates that there are many sources of thinking and writing about mothering under duress, and yet mothers’ views are rarely represented. In other words, whether in policy documents, represented as ‘cases,’ or in the news, women who are mothers are encased in a web of linked discourses affecting attitudes toward them and their fetus or child.
A Framework for Policy Development for Mothering & Substance Use

As a result of our media discourse analysis and analysis of the mothers’ views regarding policy affecting mothers who use substances, we derived a policy framework based on a set of explicit policy values. See Figure 1.

![Diagram of Mother-Centred Policy Values](image)

This framework was devised to reflect and rebalance the evidence emerging from the discourse analysis, and to highlight values more explicitly as a base for devising policy that would be mutually beneficial to both mothers and their offspring. The policy values statement highlights the eight key values that are important in redesigning and evaluating policies and in making them mothering-centered and balanced. Figure 1 depicts the values that matter in developing and assessing policy regarding mothers; it places the mother-child relationship at the centre, ensuring its primacy in discourse. It specifically suggests a shift away from assessing and affecting the interests of children separately from their mothers, instead making the mother-child relationship the unit of consideration against which we assess the values brought to developing and assessing policy. All the other mother-centered values pivot around this central paradigm shift. Policies affecting mothers and mothering must be underpinned by inclusivity, an acceptance of reasonable risk, respect, the assumption of the permanence of the mother-child relationship, support, involvement of mothers, optimism about mothering, and comprehensiveness.

In addition, a policy filter was proposed as a tool for policy makers, politicians, service providers, media personnel, women, and the general public to use to identify the approach, inherent biases, conceptualizations, and consequences of a policy or piece of legislation. The
filter is a set of questions that employ various lenses (such as gender, race and diversity) and provide ways of considering authority, process, and the consequences of policy. Finally, a set of implementation strategies was proposed to offer a set of steps for improving capacity for policy analysis and assessment among all parties.2

Using the Framework in Current Professional Education & Exchange Contexts

From 2006 to 2008 the policy filter and strategy tool have been utilized in two knowledge exchange settings, one provincial and one national in scope. Both initiatives were aimed at professional education and exchange and both allowed extensive time for discussion and debate.

Provincial professional education: The tools have formed part of the frame for a province-wide professional training program carried out between 2006 and 2008 in BC, a program focused on enhancing providers’ and policy makers’ responses to mothering and substance use, and giving them tools to think about these issues differently. The program engaged over 3000 providers and policy makers in conference, rounds, and community-based training settings (described below), and offered intensive discussion opportunities regarding how concepts of risk, rights, and evidence related to pregnancy and substance use were being applied in public health, child protection, substance-use treatment, and related settings in BC. This opportunity was used by the trainers to examine more closely the attitudes of providers and the responses to a suggested framework that treated the interests of mothers and their children as inseparable.

A wide range of professionals—including physicians, public health nurses, acute care maternity nurses, midwives, doulas, mental health counsellors, addictions service providers, anti-violence workers, child protection workers, other social workers, Aboriginal service providers, infant development workers, prenatal program providers and many other types of service providers—were brought together in rounds (physicians) and multidisciplinary community-based training sessions (all other providers) on the topic of pregnancy and substance-use issues (with a primary focus on alcohol and tobacco) in more than 45 urban centres across BC. At the opening of these training sessions, three key points of evidence were introduced to these professionals: the negative portrayal of substance-using mothers in the media;3 the shame about their substance use, and the mothers’ fear of losing custody of their children when they need to access help for substance-use problems;4 and the health risks posed for mothers and children if mothers’ health

---

2 The policy filter and set of implementation strategies appear in Greaves and Poole (2007) and in an earlier version in Greaves et al. (2002)

3 As evidenced by the Mothering under Duress study (Greaves et al., 2002), and more recent articles such as Moneo (2007).

4 As evidenced by the study of barriers to treatment by substance-using mothers conducted in Prince George and Vancouver BC outlined in Poole & Isaac (2001).
and reduction of problematic substance use is not supported before, during, and after pregnancy. Based on this evidence, a mother-centred approach to working with women in the perinatal period was proposed and discussion invited.

In these sessions, the participants were engaged in a discussion of a mother-centred approach that privileges the mother-child relationship. Key aspects of the mother-centred policy framework in Figure 1 were often immediately voiced and affirmed, especially those relating to comprehensiveness, inclusivity, respect, and involvement. However, less likely to be readily volunteered or elicited were the remaining four policy values: optimism (that mothers with substance-use problems would succeed at stabilizing, healing, and mothering); support (that mothers would be offered support to strengthen them to succeed at stabilizing, healing, and mothering); risk (the willingness to take a chance on mothers); and the value requiring the most fundamental shift to the prevailing paradigm, that of starting from an assumption that mothers will have their children (as opposed to starting with the likelihood of removal as the core assumption).

It appeared that, like the mothers who reflected on the policies affecting real life substance-using mothers, the service providers were clearly affected by the dominant negative discourse towards women who use substances and/or have addictions. The service providers wrestled with a positive, affirming approach in this situation. For some, most influential was the discourse related to a fear-based understanding of addiction, or to the primacy of child’s needs. Frequently, service providers worried that in proposing a mother-centred approach they were in some way endangering children or forgetting women’s partners. They spoke about how risky it would be for them ‘to take a chance on mothers’ within the context of their duty to report child abuse, and from their own understanding of addiction. It appeared to be challenging for some providers to envision working from a positive women-centred or mother-centred framework, both to guide their work within these systems overall, and when considering the concrete situation of an individual mother they would encounter. In spite of working in contexts that used patient-centred and client-centred approaches, many found it difficult to imagine applying such a framework to mothers, especially to mothers who use substances.

For others the challenge was to find a way to support mothers that was congruent with their personal and professional ethics, clinical wisdom, and humanity and with the strictures of systemic policy and discourses. Often a real discouragement was expressed as to their capacity to shift systems that denigrate or fail to support mothers. Indeed these instances brought to life the discourse involving the system’s responsibility regarding substance-using mothers: the providers saw little opportunity to change that system, especially from their vantage point working within it. This is consistent with Karen J. Swift’s analysis of the bureaucratization of the social work profession:

> although social workers are supposed to be ‘professionals’ and thus to bring to their work ideas applying to specific clients, the overall goals, organization, and planning of the work are established at management levels and are coordinated to social and economic processes upon which they are dependent to some extent (1995, p. 53).

As evidenced by the range of research on fetal alcohol spectrum disorder, the evidence review of best practices in smoking cessation for pregnant women Greaves et al (2005) and the research on extremely high smoking relapse rates in the postpartum period.

The sessions went on to teach harm reduction principles for working on substance-use issues and collaborative counselling skills that contributed to a shift to a more optimistic outlook by providers. Such evidence-based collaborative approaches, which support paced and achievable change, have been found to increase satisfaction by both provider and client on the individual counselling session level (Rollnick, Miller & Butler, 2008).
The values and knowledge base of the local child welfare agency’s manager, team leader, or supervisor was described as key in supporting substance-using mothers. Child protection workers and other service providers working with substance-using mothers reported that local managers’ interpretations of the legislation and provincial policy varied widely across the province. For example, some child welfare managers saw the importance of providing support to women to find housing, eat well, reduce their substance use, and improve their health and stability in other ways when pregnant, while others narrowly interpreted the provincial guidelines to providing support (or scrutiny) only after a child was born. The impact of the prevailing web of discourses on managers limited the power of individual workers to work differently, to balance the needs of mothers and children.

National Virtual Communities: The media discourse analysis, research on barriers to treatment for mothers who have substance-use problems, mother-centred policy values, and strategies for action and inclusion of mothers in policy processes were also introduced in the course of the examination of research, policy, and practice relating to mothering, substance use and child welfare undertaken by a virtual community of practice. The virtual community comprised a voluntary group of thirty Canadian researchers, policy advocates, and service providers from the child welfare and substance-use fields who ‘met’ in a virtual community over the period from January to September 2007. Participants in the online community discussed the responses on the part of the child welfare and addictions treatment systems to mothers who use alcohol, tobacco, prescription drugs, and illicit drugs. They collectively developed information sheets describing dilemmas in the current response as well as practices that were promising in addressing the dilemmas. In this virtual community setting, there was more opportunity to consider the response to substance-using mothers by the child welfare system as well as the addictions treatment system over an extended period of time, through a collective examination of literature, synchronous virtual discussions of practice and policy, and collaborative preparation of consensus documents.

In the virtual community context, the women-centred framework was even more sharply challenged. For example, the value of optimism (underlying positivity and hope that mothers will be able to succeed at mothering) was questioned when the following points of evidence were proposed to be included in a list of facts about mothers who use substances and the impact on children in an information sheet (Virtual community, 2008a):

- It is estimated that 18% of mothers engaged with the child welfare system have alcohol problems and 14% have solvent or other substance use problems. (For fathers the comparable rates were 30% alcohol and 17% solvent or other substances.) In fact, higher risk factors for substance use problems for mothers, most often noted by child protection workers were domestic violence (51%), lack of social support (40%) and mental health issues (27%) (Trocmé & Wolfe, 2001).

- Some children of substance-using parents develop no significant problems related to their parents’ substance misuse. The risks of adverse effects are higher if co-factors are operating, such as: domestic violence, both parents being substance misusers, exposure to criminal activity and witnessing someone injecting drugs (Velleman & Templeton, 2007).

- The Sheway program in Vancouver has found that, when supported, 58% of mothers with substance use problems were able to retain custody of their children. Notably, however, both Sheway and the comparable Breaking the Cycle program in Toronto emphasize that the overall lack of services for mothers with substance use problems puts great stress on

The virtual community was one of a series of six sponsored by the British Columbia Centre of Excellence for Women’s Health and co-sponsored by the Canadian Women’s Health Network and the Canadian Centre on Substance Abuse. The overall project piloting virtual communities as locations for participatory action research and knowledge translation was funded by Health Canada. See www.coalescing-vc.org
their capacity to parent (Poole, 2000); Motz et al., 2006).

Community members expressed disbelief at the low level of substance use on the part of mothers with children in the child welfare system found by Trocmé, and wondered if the findings of Velleman and Templeton should be ‘balanced’ by findings of studies showing significant negative impacts experienced by children of substance-using parents.

Again, in this context, the mother-centred policy values of support, risk and assumption of permanence were most often challenged. For example, when generalizing statements such as the following were proposed, it was argued that we should be careful not to imply that child welfare workers were seeing substance using mothers as bad mothers, only that that was a ‘systemic’ view:

_Mothers with substance use problems are often failed by the health and social service systems that are intended to assist both them and their children. This failure is associated with the stigmatizing view of pregnant women and mothers with substance use problems as “bad mothers” who are wilfully abusing substances and deliberately harming their children. Furthermore, pregnant women and mothers using substances are often perceived as not willing or able to change (Mothering and Substance Use, Info Sheet 1)._"

Those working in child welfare systems also challenged the ‘support’ value when they stressed they are mandated by legislation to protect the child, and their system was not necessarily intended to help mothers. Indeed, this legislative mandate to focus on the child’s interests makes it difficult for child protection workers to see a linked responsibility for the health of mothers.

The ‘risk’ value was also contested. For example, positive strengths-based approaches that engage families in the development of service plans that recognize their strengths, needs, and resources were seen to be relevant only for families at lower risk, in spite of evidence that this approach is working well with families at all levels of risk in the UK (Social Exclusion Task Force, 2007). There, it was found that when programs were able to ‘think family’ or provide tailored, flexible, holistic services that focused on the needs of the parents as well as the child, they were able to empower even the most challenging and disadvantaged families and turn lives around dramatically. All in all, while many positive advances in programming for mothers who use substances were discussed and documented by the community of practice, and were reflected in the information sheets produced, a full endorsement of the values-based, mother-centred framework was not generated. The greatest obstacle to acceptance of the framework seemed to be its fundamental positivity, including ideas such as strengthening the values related to the potential of mothers with the provision of key pragmatic supports, working from an optimistic stance, and starting with the assumption that mothers will have their children.

**DISCUSSION**

Based on a 2002 analysis of media discourse which portrayed very negatively pregnant women and mothers who use substances, and based on the insights of mothers who participated in focus groups, we proposed a framework of values to guide practice and policy affecting mothers who use substances. The framework was developed in response to the tone of media reports and policy documents that assign responsibility to mothers and not to the systems of support or policies that fail to support women’s health and roles as mothers. These attitudes have affected the evolution of mothering policy, and the relegation of mothers’ rights to a secondary position when these are set against the ‘best interests of the child.’

In 2006-07, with the support of provincial and federal governmental funding, we shared key elements of this policy framework with urban service providers and health system planners in two educational contexts. We clearly found that the framework and its underlying values are...

---

8 See www.coalescing-vc.org--subsection on mothering.
far from accepted as practice among the two groups (while recognizing that many individual service providers struggle to support and care for the clients they serve). The web of discourses, identified in 2002, dominated by media and child welfare policies but also including medical practices, legal decisions, treatment philosophies, and many other interlaced discourses, remains deeply embedded among practitioners. Indeed, unwarranted, harsh judgments of mothers who use substances persist, as does the view of competing rights of mother and child, where mothers’ rights to respect, treatment and to function as a parent are subsumed by the rights of the child. It appears that the assumptions underlying the prevailing discourse are more powerful than the evidence that undermines it.

Some child welfare professionals reported limitations in their ability to respond to the needs of mothers based on their view of the legislated mandate on the protection of children’s safety as primary. To them, the legislative framework forces the belief and practice that children’s interests cannot be protected in harm-reduction settings or when mothers’ rights are taken into account. This creates a profound contradiction. Similarly, the value of early attachment creates tension concerning the removal of children from their biological parents. Further, value placed on more active and self-determining roles for parents in decision-making may often collide with the overall implementation of child welfare policy. Fundamental change must occur in systemic values and practices before any meaningful change in child protection workers’ practice can improve outcomes for mothers and children.

Indeed, child protection workers did not, and, as we came to see, perhaps could not, endorse the mother-centred framework that fuses mothers’ rights and children’s rights, linking the interests of mothers and children at all junctures rather than seeing them as competing. Perhaps they did not see how it fit with current child protection practices, given the constraints of the system. Indeed, our experience in these professional educational and exchange contexts is that children’s rights and the rights of women who use substances while mothering remain separate, fed by different value systems and fuelled by contrasting discourses.

So where does this leave the many urban mothers with substance-use problems and the systems that support them, and how can professionals be empowered to shift their practices? Analyzing the discourse of risk, rights and evidence may help create more and better resources for workers, and may also influence policy makers and legislative initiatives. Both of these efforts need to focus on emerging evidence comparing holistic, strengths-based models to narrow and problem-focused models of determining service plans for mothers involved with the child welfare system. Models are being advanced in jurisdictions such as Ontario (the Toronto Children’s Aid Society’s Family Case Conferencing model and the Early Childhood Development Addiction Initiative), Alberta (Enhanced Services for Women), and the UK (Think Family) that have the potential to shift the child welfare and substance-use service and policy paradigms to strengths-based, collaborative, and supportive ones. All of these initiatives (and others) are described and sourced, in the information sheets produced by the virtual community (Virtual community, 2008b, 2008c).

These initiatives represent emerging attempts to recognize the strengths, needs, and resources of pregnant women and mothers, and proactively assist them to access the services they need to succeed at improving their own health and the health of their children, and to be able to retain custody. These approaches are characterized by respectful, multi-system responses to mothers and families, that involve meaningful inclusion of parents in identifying goals for their health and the well-being of their children. Improved relationships with children, increased access to supports and treatment and improvements in many areas of health are being documented through the implementation of these models (McGuire et al., 2006; Watkins & Chovanec, 2006).
CONCLUSION

As in the field of harm reduction, a focus on the rights of mothers to health care (and the risks of not providing it) and women’s right to determine the type and extent of intervention and care needs should be brought to the fore in our service and policy responses to mothers and children. Possible rights discussions that are yet to be fully developed should include the rights to health, to appropriate and timely health care, and to the maintenance of family connections (including the rights of children to have contact with their parents). The slogan of ‘nothing about us, without us’ arising from consumer advocates in a variety of groups remind us that successful outcomes are often linked to the involvement of service users in defining preferred outcomes (Charlton, 2000).

Specifically, there is a groundswell of evidence arising from many maternal addiction outreach programs across Canada that emphasize respect for women with substance use problems, reducing harms associated with their substance use, and care supportive of the mother-child unit (Virtual community, 2008b, 2008c). These practices, and evaluations of their effectiveness, need to continue to become more visible, not only as a form of resistance to the pervasive negative discourse surrounding substance use by mothers, but also as a contribution to evidence-based practice and improved policy-making regarding mothers, and, indeed, their children.

REFERENCES


Ahmad, N., Poole, N. & Dell, C.A. (2007). Women’s Substance Use in Canada: Findings from the 2004 Canadian Addiction Survey. In N. Poole & L. Greaves (Eds.), Highs and Lows: Canadian Perspectives on Women and Substance Use. Toronto, ON: Centre for Addiction and Mental Health.


Poole & Greaves: ACHIEVING BALANCE IN POLICIES

Association for Research on Mothering, 6(1), 16-27.


Watkins, M. & Chovanec, D. (March 2006). Women working toward their goals through AADAC Enhanced Services for Women. Edmonton, AB: AADAC.