Until the First Breath:

Limitations on Pre-natal Child Protection Intervention

Robert S. Wright

1997

Until the First Breath: Limitations on Pre-natal Child Protection Intervention

Several years ago, while working as a child protection worker in Halifax, Nova Scotia, I was first presented with a case scenario that caused me to consider the issue of pre-natal child protection intervention. My client was a 25 year old African Canadian woman. She and her 3 year old son lived with her mother. She had a 7 year old son who was living with his father in another province. When the case first came to my attention my client was six months pregnant, was a known crack addict and had been missing for several weeks.

The case was reported by my client's mother who was no longer able to care for her 3 year old grandson. The child was taken into care and immediately the questions and demands began to be asked: "What are we going to do? That woman is probably on a 24/7 (24 hours a day, 7 days a week) high! We need to find her!!" What is the Province's responsibility to protect the life and health of the unborn child? Does that change when the child will almost certainly suffer dire medical and social consequences as a result of the mothers' behaviour while pregnant? A recent case in Canada has sought to formally test this question by asking the court to approve mandated treatment for a client remarkably similar to the above mentioned case.

On or about August 2, 1996 the Winnipeg, Manitoba office of Child and Family Services petitioned Court of Queen's Bench Justice Perry to order the involuntary detention and treatment of a 22 year old, pregnant woman who was addicted to crack cocaine. The particulars of this specific case are extremely powerful and are probably the reason that the agency took this matter before a judge. The woman has three other children that have been taken into care. Two of these have continuing health problems caused by their mother's substance use when they were yet unborn.

Legal Reaction to Fetal Abuse

At first glance the Winnipeg case listed above seems shocking and rare. But a closer look at recent trends in American jurisprudence suggests that the issue of fetus abuse is getting an increasing amount of attention . Some sample cases are noted:

In South Carolina on July 15, 1996 the state Supreme Court ruled 3-2 against a woman who appealed her sentence of an eight year prison term for child neglect. The woman was convicted of smoking crack cocaine when she was pregnant (McDonough, 1996, July 21).

In Wyoming in November of 1989, a 29 year old woman was charged with endangering her unborn child. The prosecution argued that the woman's excessive alcohol consumption put her unborn child at risk. Though the charges were dismissed it raised serious questions about the issue of fetus abuse, fetus rights and women's rights to privacy. Interestingly, the public defender who served as a court appointed advocate for the woman's minor children, later called for legislation that would protect unborn children (Pelkey & Quarterman, 1990, February 4).

In 1987 Pamela Rae Stewart is arrested by law enforcement agents in California on charges connected with the death of her two month old son. Her crime: Failure to follow her physician's warnings against having sex and smoking marijuana in the latter stages of her pregnancy. Her activities were legally defined as failure to furnish necessary care for her child. The child was born brain-damaged and died two months later (Taylor, 1989, March 31).

A very innovative twist among fetal abuse cases involved a Florida woman being jailed on charges of giving cocaine to a minor. Though the law was designed to combat school yard drug trafficking, the minor in this case was the woman's unborn baby. Her child

was born addicted to cocaine as a result of the woman's substance abuse in the later stages of her pregnancy (Taylor, 1989, March 31).

This variety of legal responses to fetal abuse is consistent with the list of currently employed responses discussed by Madden (1 993). He asserts that there are four different ways that the state has attempted to restrict the potentially hazardous behaviour of pregnant women: Use of the criminal code to restrict all such behaviour, use of the criminal code to restrict just illegal behaviour, use of family law to restrict all behaviour whether legal or illegal, and reliance on current language and policy to guide case by case decision making. Though these various responses are presented as existing on a continuum, it would seem to date that all have resulted in the same type of response: A punitive one.

Science and the Law

The issue of fetal rights and fetal abuse is a complex mixture of advanced medical technology, medical ethics and law. That a fetus is valuable and, to some extent, has rights is well established. Ancient texts such as the bible proscribe certain punishments to those who might cause an unnatural abortion by injuring a pregnant woman. It appears that English common law allowed abortions to be performed prior to the 'quickening' - time at which the fetus is first evidenced to be moving at about 1 6 or 1 8 weeks - of the fetus. Laws prohibiting abortions altogether were not enacted in the United States until the latter part of the 18th century (Roe v. Wade, as cited in Baird & Rosenbaum, 1993).

The famous Roe v. Wade case legalized abortion in the United States in 1972. This landmark case recognized that the issue was brought to the court as a result of emerging medical technology. The case then was directly opposite to the case now. In 1972 it was partly argued that the historical prohibition against abortion was due to the hazards such a procedure has for women. In 1972 modern medical technology significantly reduced the

woman's risks (Roe v. Wade, as cited in Baird & Rosenbaum, 1993). The argument now is that advances in medical technology are able to monitor and care for the health of a fetus as if it were a separate entity from the woman carrying it (Wood, 1996, August 19; Madden, 1993).

The pace of advances in medical technology in the area of fertility and reproduction has been so great in recent years that legislators and even medical ethicists have been unable to keep up. Today doctors regularly extract ovum and sperm from would-be-parents, fertilize them in-vitro and freeze them for later use. Thousands of such potentially viable fetuses are destroyed each year by parents who have either successfully given birth or who no longer wish to pursue expensive therapies. The ability to determine birth defects and physical characteristics by means of genetic testing opens up a completely new area for legal consideration; that of selective child rearing (Wood, 1996, August 19). Already the practice of aborting unwanted female fetuses has become so large spread in Canada that certain jurisdictions refuse to identify gender in-utero.

Given the state of medical technology the intrusion in the lives of pregnant women like those listed above is potentially only a beginning. Society's compassion and economic interests - given the cost of caring for a developmentally or physically disabled child - seem to be the motivating factor in such cases. How long will it be before the certainty of diagnostic and intervention procedures involving genetic technology will make it seem like a crime to give birth to a child with a 'treatable' hereditary disease or developmental disability?

The medical nature of the fetal abuse dilemma has prompted some Canadian physicians to bring the matter to the floor of the annual meeting of the Canadian Medical Association. The resolution called for the Association to pressure the federal government to review legal protection for unborn children in cases in which mothers clearly put their unborn children at risk. The Association declined action and referred the motion to its board of

directors. Clearly this national medical organization is unprepared to debate the issue at this time (Doctors skip fetus-rights debate, August 22, 1996).

Developments in legislation and medical technology have left us with an ethical dilemma. How is it possible for a society to both permit abortion and at the same time restrict the freedoms of a woman who chooses to carry a fetus to term no matter how reckless her behavior7

Implications for the Child Welfare Worker

While medical professionals and lawyers will contribute significantly to the question of what to do with cases of apparent fetal abuse, social workers, and particularly child welfare workers, must facilitate the debate. Thus far the phenomenon has been responded to with such urgency and public outrage that the principal at the foundation of modern child welfare has seemingly been ignored. The ability to protect children, while at the same time working to strengthen and support families, must become the goal of proposed interventions (Madden, 1993). From a family welfare perspective, current interventions in cases of fetus abuse have been counterproductive.

If responses to cases of fetal abuse results in criminal proceedings against would-be moms and the apprehension of the child at the moment of birth, the effects of this policy must be considered. A Punitive response will make parents engaged in risky behaviours unlikely to seek medical or social services. This will further endanger the health of children. Contentious battles which pit the rights of the fetus against the rights of parents may also have the effect of creating hostilities between parent and child which will complicate maternal-fetal and parent-child bonding. Of course incarcerating pregnant women will ensure parent child separation at birth and likewise contribute to bonding and attachment difficulty.

Another concern for social workers in general is the use of criminal law against women whose activities are driven by a chemical addiction. The issue of fetal abuse in the face of chemical dependence is a very clear example of the futility of a criminal justice response to a psychological condition that requires intervention, not prosecution (Gustavsson, 1991). Social workers should not be agents of a system that would lock up pregnant, chemically addicted women. We should be advocates for structural change to redefine the issues.

The issue is not about uncaring, ignorant, would-be-moms. The issue is race, class, education and unemployment. To date this writer has not seen a single case of fetal abuse reported among members of the middle and upper classes. More affluent members of society experience greater access to health care and proprietary addiction treatment services. They also tend to suffer less from both the societal and individual victimization that is experienced by poor people (among whom racially visible people are over represented). Such victimization is often the genesis of the psychological foundations of addiction.

The issue is not about dramatic rescue attempts in extreme cases of prenatal chemical addiction. The issue is about the introduction and support of harm reduction models of re-conceptualizing fetal abuse. Harm reduction is a term most often used in the field of chemical addictions. Rather than focusing on abstinence as the sole solution, harm reduction philosophies focus on attempting to reduce the biological, psychological and environmental impact of addiction. These interventions might include providing clean needles to intravenous drug users, providing shelters for hard to house addicts and providing safer, alternative pharmaceuticals, such as methadone, as a means of managing addiction. If such interventions were offered to pregnant women, the harm to their fetus might be substantially reduced. The provision of harm-reduction-informed pre-natal and post-natal family care services would significantly reduce the barriers to disclosure that currently exists.

Case Example

At the beginning of this paper this writer introduced a case which illustrated the phenomenon of fetal abuse. The same case might serve as an example of a harm reduction intervention. When the client in question went missing the worker arranged to take the abandoned child into the care of the agency. Using contacts in the community the client was contacted and explained that this was a temporary measure that was taken to ensure the immediate welfare of the child and that efforts would be made to reunite the two as soon as possible. Though the client continued to remain on the run the child welfare worker was able to meet with her on occasion for support and encouragement and to provide her with nutritional supplements and consultation regarding prenatal care and post-delivery planning.

When the client went into labour she checked herself into the maternity hospital. Staff there had been previously alerted to watch for her. As partners in the plan, staff at the hospital provided supportive and encouraging care, keeping the mother fully appraised of the child's health and including her on all decisions related to the care of the child. Staff also provided support and understanding about the clients substance abuse issues. As planned previously with the client, the child was formally apprehended at birth but remained in her physical care while in hospital.

Parent child contact was continued by placing both children (the new infant and 3 year old son) and their mother in the home of a suitable restricted foster home. The placement was with a young, single mother who had experience dealing with family members who had chemical addictions. Over the next three years parent child contact was successfully supported. Though the periodic substance use continued when the client would spend weekends and overnights with friends, the client's addictive behaviour never endangered the care of the children.

The client had several failed attempts at treatment for her dependency and the legislation's timelines ultimately required the agency to make permanent placement arrangements for the children. The children were placed together in a loving home with a woman who had served as their respite foster care worker over the previous three years. The client was familiar and comfortable with this placement and though saddened by her inability to maintain legal custody, was happy that the children were not placed with strangers. Because of the nature of family network within the Black community the children continue to receive news and periodic visits from their mother. They remain in contact with their natural extended family through church and community activities. Though no formal arrangement has been made, all parties see the potential of mother one day becoming a more significant part of the children's lives as they become older and she more successful in rehabilitation.

Though the mother ultimately relinquished custody of her two children, the bonding and attachment needs of the children were met. Continued knowledge of their parents and contact with biological family was also preserved. Throughout the process the court was satisfied that at no time was the care of the children jeopardized.

Such a case is an excellent example of interagency cooperation and creative case planning which placed the goal of protecting children firmly in the context of preserving family. That the judge who presided over the matter was herself an African Canadian woman with a vision that went beyond the punitive response of criminal legislation was critical to the overall plan.

Conclusion

Advances in medical technology which enable us to predict and monitor the deleterious effect of parental behaviour on fetal development creates a whole new area of societal concern. The speed at which technology has come to this place has left us without

the appropriate legislative and policy guidelines to direct successful interventions. As if affected by future shock society seems likewise to be caught without a long-range vision of the effects of interventions hastily applied.

As child welfare workers are enlisted to respond to the issue of fetal abuse they must take the helm. Leading the development of innovative programs and services will require all the knowledge, values and skills of our profession. Fully collaborating with medical and legal professionals will increase the chances of creating a seamless plan that protects children, reduces the harm to fetuses and respects the rights and provides for the needs of parents.

Recognition of and sensitivity to the gender, race and class implications of this issue will heighten the practitioners awareness of the need to move slowly in the development of sweeping policies. Careful consideration must be given to include those traditionally disenfranchised when systemic planning is undertaking at the agency, community and legislative level.

References

Baird, R. M. & Rosenbaum, S. E. (' 993). The Ethics of Abortion: Pro-life vs. Pro-Choice. Buffalo, New York: Prometheus.

Doctors skip fetus-rights debate (August 22, 1996). The Daily News Worldwide [On-line], Downloaded on the day of publication: HTTP://www.hfxnews.com/

Edmonds, S. (1996, August 3). Rights of mom, unborn child to collide in Winnipeg court. The Chronicle Herald [On-line]. Downloaded on the day of publication: HTTP://www.herald.ns.ca/chronicle/sat/free/articles/free6.htmI

Gustavsson, N. S. (1991). Pregnant chemically dependent women: the new criminals. Affilia, 6, 61-73.

Madden, R. (1993). State actions to control fetal abuse: Ramifications for child welfare practice. Child Welfare, 52, 129-140.

McDonough, M. (1996, July 21). S. C. trying to clear up fuzzy line on fetus abuse. Spartanburg Herald-Journal. (From Newsbank Reference Service Plus, 1996, LAW 55:A5)1

Pelkey, C. & Quarterman, E. (1990, February 4). Attorneys in Pfannenstiel case say ruling win for privacy rights advocates. Casper Star- Tribune. (From Newsbank Reference Service Plus, 1990, LAW 15:C13)

Taylor, F. G., (1989, March 31). The endangered unborn. Hartford Courant. (From Newsbank Reference Service Plus, 1989, HEA 107:F13

Wood, C. (1996, August 19). Beyond abortion. MacLean's, XXX, 14-15. (This paper is a greatly expanded discussion of the issue presented in article one of the Current Events Log.)