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Pregnancy and substance use – the Norwegian § 10-3 solution.[1] Ethical and clinical reflections related to incarceration of pregnant women to protect the foetus from harmful substances

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ABSTRACT

AIMS – This article highlights ethical and clinical dilemmas of incarceration of pregnant drug addicts mandated by § 10-3 of the Norwegian Municipal Health and Care Services act. MATERIAL – The material consists of two cases, Siri and Anna, and the ethical dilemmas posed by the use of § 10-3 in these cases. METHODS – Semi-structured in-depth individual interviews were conducted, audio-recorded and transcribed word for word. Transcripts were coded according to converging interests and possible ethical dilemmas and described in a case format. The practical and experiential consequences of the law are discussed in relation to the four main bioethical principles: respect for autonomy, non-maleficence, beneficence and social justice. These are supplemented by the principles of relational ethics. RESULTS – The application of § 10-3 may lead to situations which distort the psychological preparation for parenthood and strains the helping relationship. The four principles approach seems to be an insufficient tool in grasping the complexity of the situation. CONCLUSIONS – Interventions to protect the foetus from the pregnant woman's use of substances demand elevated professional awareness of ethical and relational challenges and dilemmas. Relational ethics provides a framework to enhance reflexivity and a trusting therapeutic alliance. The potential for psychological change during pregnancy should be invested in. Hence, we suggest that during incarceration according to § 10-3, foetal protection and the promotion of parental competences should be given equal priority.

KEY WORDS – Addiction, coercive treatment, ethical dilemmas, motherhood, pregnancy, relational ethics.

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Introduction

Maternal substance addiction imposes several risks on the offspring from conception on. Most chemical components of the substances pass the placental barrier and represent a developmental hazard to the growing foetus (Moe et al. 2010). Pregnant women often find themselves torn between the wish to protect the foetus and failure to do so (Söderström 2011). The situation causes worry as well as moral indignation, and the welfare system is urged to act. In 1996, Norway passed a unique piece of legislation, at the time § 6-2a in the Social Service Act, now § 10-3, which made it possible to incarcerate pregnant drug-addicted women in order to protect the foetus. Although the paragraph is grounded on the ethical principle of non-maleficence, there has been raised concern for unintended negative effects such

as increased abortion rates and reluctance to seek health services (Søvig 2011). The paragraph has been evaluated from the perspective of the social worker (Lundeberg & Mjåland 2009) and in terms of neonatal outcomes (Nordlie 2006). The ethical dilemmas have been discussed from a legal perspective (Søvig 2007; Nilssen 2005). During the fifteen years of practising the paragraph, no publications have drawn on the clients' experiences to discuss ethical dilemmas and consequences of the paragraph. It will be done in this article.

Despite the perceived clarity and legitimacy of the paragraph among Norwegian law-enforcers (Lundeberg & Mjåland 2009), none of the Nordic neighbouring countries has so far adopted it. The Danish, Finnish and Swedish debates have been more influenced by questions of the juridical status of the woman versus the foetus (Leppo 2009). An awareness of uncertainties and gaps in our knowledge on foetal development and substance exposure has led to a different conclusion: the woman is granted "freedom" until more is known (Mäkelä 2009). Hecksher (2009) expects that women in Denmark already known by the social welfare apparatus will more often be subject to intervention compared to those with equally harmful substance use, but with higher socio-economic status. Another problem is that Danish legislation does not treat a foetus as a legal subject and thus it cannot be given legal rights. In Finland, the discussion of the issue in the 1980s led to increased efforts within voluntary treatment (Leppo 2009). A core argument was that intrinsic motivation is necessary for building a therapeutic alliance and for lasting change. In 2010, the proposed changes in Swedish legislation similar to Norway's § 10-3 were turned down by the government. Opponents of the proposition had similar doubts as Hecksher (2009) in terms of treating the foetus as an independent legal subject, thus opening up for reinterpretation the foetus' right to protection versus the woman's right to self-determination (Runquist 2009). To sum up, the main issues in the Nordic debate have been the legal status of the foetus, patients' rights, the right to autonomy, the therapeutic alliance and motivation, and a skewed effect of the legislation mostly targeting underprivileged women. Issue 3 of the *Nordic Studies on Alcohol and Drugs* (2009), which thoroughly discussed these questions, contained no Norwegian contributions.

Although the use of coercion against women to protect the foetus is a controversial principle, social workers find the paragraph relatively easy to use because foetal development and the health of the baby are at stake (Lundeberg & Mjåland 2009). Still, incarceration during pregnancy against the woman's will involves a difficult balancing act between individual autonomy, foetal protection and promotion of caregiving competence. This balancing act is handed to the professionals at the clinics to solve.

In this article, we use the cases of two women to identify situations, experiences and practices that are ethically challenging or saddled with contrasting interests. We bring the clients' experiences into the debate, presenting another angle on the ethical dilemmas and professional challenges. The two cases will be discussed in relation to ethical guidelines of clinical practice, patients' rights and human rights, as well as in relation to existing

research on coercion, addiction and pregnancy. Implications for professional and ethical practice are proposed.

Ethical challenges in reproductive health

The issue of female reproduction has always been loaded with different moral and cultural norms and regulations. Both the socio-cultural setting and the available medical knowledge and technologies have influenced women's own choices and the interventions they have been subjected to. Complications during pregnancy and birth sometimes raise questions of who should be medically prioritised, the woman or the foetus. Until little over a century ago a Caesarean section was performed to save the baby when the mother could no longer be saved. When the mother's life could be saved in obstructed labour, a cranioclast was used to crush the baby's skull to facilitate delivery. Newnham (2003) has examined the rights of pregnant women to decide what can be done to her by medical personnel without her consent, even if the intervention is considered to be in the best interest of both or the foetus/child. She found that the medical considerations often favour foetal health, whereas the legal conclusions are that the woman's rights should not be overridden in favour of the foetus.

Different practices and views depend on the status given to the foetus. Norwegian legislation demarcates what is to be considered a future human being and what should be considered a medical condition. It also defines limits for a woman's right to control her body and the rights of the foetus to be protected. However, legislation alone does not necessarily dissolve the dilemmas; § 10-3 protects the foetus from the mother's use of substances at a stage of development where she is free to have an abortion.

The pro-choice abortion discourse avoids referring to the foetus as a future child, at least within the limits of self-determined abortion. The pro-life movement considers the foetus to have the same rights as any living human. What can be called *the Norwegian § 10-3 discourse* presents a view of the foetus as a future child from the moment pregnancy is confirmed. It is a discourse that treats the foetus as a patient. It thus becomes a part of the larger discussion about the moral and legal status of the foetus.

McCullough and Chervenak (2008, 401) suggest that in a principle-based reproductive ethical framework, the foetus is considered a patient. The authors do not grant the foetus an independent moral status, but argue that "the physician can have beneficence-based obligations to the foetus, but only when the foetus is a patient". Brown (2008, 48) critiques this view and the attempt to "smuggle in normative import". He assumes that the concept of foetus-as-patient will be welcomed into the vocabulary of pro-life advocates. While this ideological and moral debate will not be discussed in this article, we adhere to Brown's (2008, 49) second argument. Seeing the foetus as a patient highlights the "dilemmas of prioritizing between the protection of the foetus and future health of child-to-be and, on the other hand, imposing burdens upon a pregnant woman's liberty interests". Thus, we follow Brown's advice to use the term foetus to avoid value-laden connotations. For the same reason we use the term pregnant woman instead of mother-to-be.

Coercion versus autonomy

Autonomy and self-determination are seen as central to the human rights of patients. In clinical practice this has led to a stronger emphasis on informed consent, efforts to redefine patients as partners, and in the Norwegian context, to the passing of legislation that gives patients a choice between hospitals and treatment alternatives and access to their own patient records.

A noticeable exception to this development is the use of coercion in mental health and addiction treatment. The main argument for the use of coercion is that its appliance can be defended when people have lost their capacity of autonomous choice or when they pose a threat to themselves, other persons or society in general. It can be seen as one of the last strongholds of paternalism based on the principle of beneficence. Supporters of coercion argue that its practice is backed by research showing that coercion plays an important role in successful substance abuse treatment (Sullivan et al. 2008; Nace et al. 2007). It has also been argued that substance abuse in itself represents a form of coercion and that coercive treatment is therefore a necessary step on the path to regaining the capacity of autonomous choice (Caplan 2006). The argument for mandatory interventions to pregnant substance addicts is primarily related to the potential harm to the foetus. Opponents of coercion claim that substance abusers have the capacity for autonomous choice, at least when not intoxicated (Botten et al. 2003; Waal & Mørland 1999). Subsequently they argue that treatment should be offered based on informed consent and that coercion poses a threat to the treatment motivation and the therapeutic alliance, undermining important factors for a successful outcome. Both sides present arguments related to the outcome of various therapeutic strategies and consequences for the patients.

There are reasons to believe that this is a much more complex issue than a mere dichotomy between self-determination and coercion. Coercion comes in several forms, through the legal system (legal coercion), through health service providers and other formal bodies (formal non-criminal coercion) and the social environment, friends and family members in particular (informal coercion) (Wild 2006). Literature on coercion and treatment suggests a middle ground wherein coercion is perceived as a necessary strategy in the enrolment for treatment, but that a vital goal of therapy is to move in a direction where the treatment will be based on the patient's informed consent (Caplan 2008).

The combination of pregnancy and addiction is a situation where both woman and foetus are vulnerable and have special needs. To the extent that these needs are seen as opposites, professionals are challenged to balance the best interest of one against the other. Ethical principles for professional conduct can be valuable tools in navigating between clinical, legal and ethical dilemmas. At first sight, these principles may seem obvious, but a closer look shows that what constitutes ethical practice in this field is anything but obvious. The aim of this article is to lay out the dilemmas in this complex situation to enhance ethical awareness and reflexivity.

Methods and material

This article is based on an empirical ethics approach, wherein ethical reflections

are drawn from two cases. As a case-based study, this is a follow-up of a larger study in which sixteen women and eight men enrolled in family-oriented treatment for substance addiction, participating in nine focus group sessions to investigate the experience of parenthood and addiction. Empirical findings from this study have been reported elsewhere (Söderström 2011), including a detailed description of the phenomenological analysis performed. However, the finding that the women had many difficult experiences related to mandatory interventions during pregnancy led to an additional investigation of this particular experience. In this investigation, the criterion of inclusion was having been in closed ward placement during pregnancy. Two pregnant women were recruited by informed consent to individual semi-structured in-depth interviews, each lasting approximately an hour. Recruitment was based on availability within the timeframe available. Representativity was not considered. The methodology of case-based reflection assumes that the posed ethical challenges call for reflection irrespective of the number of cases involved. These two cases present ethical dilemmas that may be seen as a consequence of the application of § 10-3.

Preparation for the interviews included visits at the closed ward and conversations with the clinical staff. The interviews were conducted at the clinical site and later transcribed verbatim by the first author. Transcripts were computed into NVivo (2006) for elaboration and coding of ethical dilemmas. Both authors were involved in discussing transcripts and coding until agreement was reached about how to frame the ethical dilemmas.

For the ethical reflections, the framework presented by Beauchamp and Childress (2009) was used, wherein the principles of respect for autonomy, non-maleficence, beneficence and social justice are central. Our discussion will be centred on the three first principles, but we fully acknowledge that social justice plays a crucial role in the wider context of the treatment of substance abuse. In addition to this bio-ethical framework, we used the concept of relational ethics to discuss how professionals can deal with hard-to-solve dilemmas. Marcellus (2004) describes mutual respect, engaged interaction, embodiment and creating an environment where trust is an essential ingredient as central themes in relational ethics. It is against this background that we present our reflections. The names are pseudonyms, and necessary changes have been made to ensure anonymity. The stories told by ”Siri” and ”Anna” have not been compared and checked with the other persons involved. We assume that the stories might have been told differently depending on both the storytellers and to whom the stories are told. However, we do not attempt to find out what ”really” happened, but rather how these women experience, digest and present their experiences in the context of the research project. A case-based methodology such as this is commonly used to discuss ethical dilemmas (for example, Schwennesen et al. 2008).

Case presentations: Siri and Anna

Siri discovered her pregnancy in the sixth month. She participated in an opioid-assisted rehabilitation regime, but had relapsed into side use. She immediately

informed her case manager about the pregnancy because *"I didn't want to be accused of holding back any information"*. The case manager and the social welfare office arranged for her to be admitted to a closed ward within 24 hours. The woman welcomed what she saw as voluntary treatment with firm limits which would help her to control her addiction during the remainder of the pregnancy. When she arrived at the clinic, Siri was shocked to find the doors locked and a substantial amount of surveillance. She wanted to withdraw her consent, only to find that if she did, her case would be "transferred" to § 10-3. and she would be incarcerated without consent. She had previously lost custody of an older child and felt treated unfairly by the Child Protection Services (CPS). Mutual trust was lacking.

Interviewer: Things were going fast at the time of the admission. Are you saying that you didn't know that you would be staying in a closed ward?

Siri: Yes. No, I didn't know, I didn't know. I knew that they could implement coercion but I didn't know…, I thought it was an open ward. […] So I was shocked to find the windows nailed shut. You cannot even lock the door to the toilet. In the mornings they come in and they sit and sit, and you have to open your mouth so they can see that you haven't taken out the Subutex. I feel very much declared to be without legal capacity, I feel weak in here.

Siri continued to stay by consent. She felt that a stay based on § 10-3 would harm her chances to keep the child. Based on the regimes and routines at the clinic and her previous experience with the CPS, she was on guard all the time and "kept her cards close to her chest". She expected that whatever she said and did would potentially be reported to CPS.

At the end of the interview, Siri was asked if there was anything more she wanted to add. Although she had already made the point, she replied: *"Yes, I want to make it clear that there is no real difference in being here by consent or by coercion. If you want to leave, or in other ways do not comply, your status will immediately be changed to § 10-3"*.

Some years ago **Anna** got divorced, which caused an unwanted separation from her child. She relates her drug problem with these events. Anna was in a rehabilitation process when she discovered that she was pregnant. She co-operated with the social welfare office to secure a clean pregnancy, but failed to hand in one of the scheduled urine tests. Although she claimed to have a reasonable explanation for this, the incident caused worry amongst the professionals, who scheduled an appointment for a home visit. Instead of the expected regular home visit, she found uniformed police and an unfamiliar social worker on her doorstep. She was asked to pack her things and come with them.

"What have I done, why are they here? I thought. I have always been on the right side of the law. In that situation I felt like a hard core criminal. And of course, people will think that I am a criminal when the police show up like that. […] I was furious, I was scared and I felt helpless. I could not understand why they were doing this to me."

Anna was sentenced to mandatory incarceration by a preliminary court decision. Prior to incarceration, she was determined to keep the child, but the incarceration made her change her mind. She immediately requested a medical consultation to have an abortion, which she was granted. However, she was recommended to wait a couple of days to think it over, and the doctor suggested that the staff kept the abortion pills. Anna was convinced that the child would be taken away at birth: *"I couldn't stand the thought of losing another child by having it taken away by others. I'd rather have an abortion."*

The following days Anna was ridden by ambivalence and strong affect. She kept asking for the pills but repeatedly either changed her mind or was talked out of it. Finally, Anna decided to carry through with the pregnancy. She was close to full term at the time of the interview, and was asked to evaluate the impact of the incarceration.*"Without it I would have continued along the path on which I had already started; no drugs and co-operating with the helping agencies. I still think that the coerced intervention was unnecessary, but I have learned a lot by being here."* She experienced the external control, locked doors and loss of self-determination as hard to endure: *"I've been living with so much coercion. I grew up with it, during my marriage my life was controlled by my husband. I've been controlled by others. I hate coercion. Freedom is dead serious to me. I hope I never will experience something like this again."*

Discussion

In a critical review of three decades of research, Klag and colleagues (2005) picture the situation in substance abuse treatment as truly complex, as to when and what kind of coercion is applied, and how elements of coercion and self-determination are intertwined in the treatment process. We find that these two cases illustrate this complexity. With Siri, the coercive element was initially hidden and her voluntariness continued only because she thought it looked better in the eyes of the CPS. Anna was incarcerated against her will, but in the last months of pregnancy she was transferred to treatment by consent.

In the following, we elaborate on the principles of autonomy and beneficence and how mandatory interventions are linked to the assumed lack of competence in the patient. Then we discuss how incarceration may also pose a threat to the foetus, and finally we attempt to find common ground between protecting and promoting both foetal and maternal interests.

Autonomy vs. beneficence

The use of coercion may be seen as an example of paternalism or "the intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this action by appeal to the goal of benefiting or of preventing or mitigating harm to the person whose preferences or actions are overridden" (Beauchamp & Childress 2009, 208). In our cases, the goal of beneficence or non-maleficence is primarily the foetus. Whilst autonomy grants people the right to make what health care personnel may regard as bad choices, paternalism presents a rationale for the personnel to override such decisions, based on the assumption that they know a person's best interest bet-

ter than the person him/herself. By incarcerating these women, the service providers remove their autonomy in an effort to avoid harm, or more preferably, to achieve beneficence. It is a prerequisite for these actions to be considered ethically acceptable that one or both of these two goals are achieved. Otherwise, it can be argued that coercive actions plainly remain violations against these women's autonomy. The justification for paternalism may thus be seen as resting on two important presumptions, the incompetence of the patient and the competence of the professionals.

The incompetence of the patient

Substance-addicted women are generally not trusted to take care of their children (Klee et al. 2002). Siri and Anna were not trusted to provide the necessary protection for their foetuses. Although they both wanted to, their willpower to resist drugs was questioned. Anna disagreed with this all through her pregnancy, whereas Siri realised that she needed help to stay sober. There is considerable evidence that severe addiction influences cognition, decisional processes and willpower both at a neurobiological and psychological level (Adinoff 2004). Staying in a drug-related environment together with other users will further lower the odds to stay sober. In the study that preceded the present one, this was confirmed by several women who tried but failed to scale down and quit on their own (Söderström 2011).

The use of coercion towards people with substance addiction is linked to the question of legal capacity and the ability to make autonomous decisions as well as to the principle of causing harm to oneself or others. Coerced treatment is seen as a necessary counterforce to the coercion of addiction and is justified as a means of restoring self-determination and freedom of will (Caplan 2008). This understanding of addiction has been questioned and criticised. The opponents of the "loss of capability thesis" (Husak 1992) argue that "Addicts are not people without willpower or people driven to act without making choices" (Waal & Mørland 1999, 45). Thus, continued use is seen as more of a conscious act. However, when a vulnerable foetus/ future child is put at risk, society is less willing to accept destructive behaviour.

The question of legal capacity can seldom be answered by a simple yes or no. It is more a question of degree, and it can also fluctuate over time and in different contexts. During severe intoxication, a person may be declared without legal capacity, but in sober periods he/she has full capacity to act autonomously. The degree of legal capacity can be used to justify mild versus strong paternalism (Nilssen 2005). Siri and Anna were not declared without legal capacity but rather declared to be without the necessary competence to resist drugs. Hence, paternalism leading to "voluntary coercion" and incarceration respectively, was probably justified by the precautionary principle of § 10-3: "the abuse is of such a nature that it is most likely that the child will be born with injuries" (translation by Søvig 2011).

In both cases decisions were taken rapidly. Siri was still trying to grasp the facts of her pregnancy. Although information was given, it can be questioned to what extent Siri's decision was an informed one. Furthermore, her decision was only accepted as long as it was in accordance

with the decision viewed to be the right one by the professionals, again an indication that this was not an autonomous decision. The prospect of direct transference to incarceration by § 10-3 was experienced as a form of power tactics. It looks like paternalism in disguise, or what Nilssen (2005) has labelled "the trick of consent". Anna was shocked by the presence of police and the unexpected admission, which almost led her to have an abortion. The paradox that Anna is granted autonomy to abort the foetus but not regarded as able to protect it will be further discussed later. The point here is that the process by which one is admitted to treatment and the style of confrontation or intervention can help or hinder treatment effectiveness (Darbro 2009).

The competence of the professionals

The combined task of providing protection for the foetus (non-maleficence) and promoting sobriety and preparing for the parenting role (beneficence) involves important challenges to the professional's competence. They are expected to provide a sense of safety and trust, and addiction rehabilitation alongside regimes of control, surveillance and mandatory reports. Processes of change are usually based on a benign therapeutic working alliance and mutual trust and respect. A trusting relationship can be difficult to establish especially if the woman feels weak and controlled. Simultaneous acts of support and surveillance will often involve attempts at concealing and disguising elements of control (Marcellus 2004). As Siri's case illustrates, such tactics easily backfire once they are unmasked, as her trust in the professionals were limited, creating a poor base for a functional therapeutic alliance. Her unwillingness to unveil her thoughts and feelings is counterproductive from a therapeutic perspective, but from her own standpoint a necessary strategy to increase her chances to keep the baby.

For Anna, the abrupt intervention brought her into a state of emotional turmoil leading to considerations of abortion. Fearing that she would lose the child anyway, she vacillated between the choice of abortion or birth. The professionals were as ambivalent as Anna herself, some highlighting her right of self-determination and suggesting the foetus was better off by not being born. Others, urging her to think it over, were concerned that the decision would be made while Anna was very emotionally distraught and that she would later regret her choice. Anna's case is similar to the one presented by Dudzinski and Sullivan (2004), dealing with the ethical challenges posed by a pregnant woman with problems of mental illness and addiction. This woman also wavered between wanting to terminate her pregnancy and to keep the baby. Faced with the challenge of whether to respect the woman's preferences or not, Dudzinski and Sullivan describe a process wherein the main focus is helping the woman to regain her ability to make an autonomous choice. However, an ideal procedure may require a timeframe that was unavailable in Anna's case. These situations illustrate the need for professional ethical and relational competence and procedures.

Incarceration implies a separation from partner, family and natural social network. During incarceration, professionals take on the role of providing social support from an informal social network. Since long-term addiction tends to result in loss

of contact with sober family and friends (Masters & Carlson 2006), a relevant issue to reflect upon is the difference between private and professional social support and the competence to support fragile families.

Pregnancy is a condition tailored for change (Stern 1995). The Norwegian guidelines for maternity care (Sosial- og helsedepartementet 2005) suggest a patient-centred clinical approach to ensure that the woman is heard and given proper support. The container-model, that is, a view of the female body as a container for as healthy a child as possible, is publicly abandoned. The two cases reported here and the findings in Söderström's study (2011) raise concern that mandatory incarceration during pregnancy may have the unintended effect of turning a pregnant addicted woman to a human container, thus missing the unique potential for psychological change. The case of Anna also illustrates the concern posed by Søvig (2007) that § 10-3 can cause pregnant women to consider abortion as the preferred alternative to coercion.

On the other hand, preliminary findings indicate that the clear priorities of § 10-3 result in positive neonatal outcomes (Nordlie 2006). Thus, in terms of securing as healthy a baby as possible, the paragraph seems to be effective. This aim would in most cases coincide with the wish of the pregnant woman. Söderström (2011) found that despite the critical remarks on loss of freedom, and the amount of suspicion and control, the women were in hindsight thankful for the assistance to protect the foetus. Anna was critical of her autonomy having been overridden, but she still said she had learned a lot from the coercion treatment. However, further research is necessary to answer the question of what the women learn and how a § 10-3 intervention influences caregiving competences in the long run.

Incarceration; protection or threat to foetus

The intention of § 10-3 is clearly to protect the foetus. Our cases do, however, illustrate that this is not as straightforward as it may seem. Anna was on the verge of having an abortion as a consequence of the way she was being treated, indicating that the outcome of her incarceration may have been just the opposite of what was intended. As already stated, Anna was not free to harm the foetus by means of intoxicating substances, but she was free to terminate its existence by means of an abortion. This illustrates ambiguity about the foetus. One aspect of the situation in Norway is that in the context of substance abuse the foetus is seen as a person to be, whereas in the case of an abortion the foetus has not yet reached the status where the right for protection is attributed to it. Another interpretation is that the incarceration can be seen as an outcome of a precautionary principle: the foetus is to be protected in case the decision on abortion is in favour of letting it become a person.

Anna's case confirms the concern that pregnant substance abusers can see having an abortion as the preferable alternative to coercive treatment or to the prospect of losing custody. If these are perceived as real options, there is reason to raise the question about the real consequences of Norway's current legislation and clinical practice. The current ethos of clinical practice is based on a precautionary principle where any substance exposure for

the foetus is to be avoided. This is the case for any pregnancy, not only those of women abusing substances. Whereas the risks of suffering damages from such exposure are on a continuum, current guidelines tend to present this risk as a dichotomy. There are reasons to believe that the reality is much more complex (Hecksher 2009; Gray et al. 2009; Mäkelä 2009).

Protection and promotion

In pregnancy and addiction what might be good for the pregnant woman, may be bad for the foetus, and vice versa. The debate is to a certain degree in a deadlock trying to weigh the personal independence and freedom of the woman against the right of protection during pregnancy to prevent children from being born without substance-related handicaps. The situation may be seen as one where professionals are forced "to take sides", either in favour of the foetus or of the addicted pregnant woman. In our understanding, § 10-3 seeks to resolve this dilemma by stating clear priorities. Non-maleficence for the foetus is prioritised before regimens for the good of the woman. We argue that this kind of prioritising can have unfortunate effects for the foetus, the pregnant woman and the practitioners. The priorities may lead to a perception among pregnant women that they are less valued, as in "We used to call ourselves the federal brooding box" (Söderström 2011). The § 10-3 does not resolve the dilemmas, which are only passed on to the clinical level. In the following, we search for alternatives based on the assumption that the pregnant woman, the foetus and the professionals are basically on "the same side".

Rather than generating heightened concerns for the foetus, as McCullough and Chervenak (2008) have done, ideal guidelines would direct clinical focus on optimising the prenatal care of the pregnant patient, on empowering her to make the best possible decisions that she can, for her sake, and that of the foetus and the future child. Wild (2006) suggests that treatment strategies supporting client choice and autonomy may increase chances of success in treatment, regardless of the social controls that may be in place. Guidelines should also include the obligation to support the woman's autonomy as a significant aspect of her overall health and well-being. Brown (2008) argues that not respecting the woman's autonomy could, in certain circumstances, be seen as violating the professional's obligation to "do no harm". There are features in Anna's case that come close to the question of whether harm was done. This case also illustrates the worry expressed by, among others, Hecksher (2009) that § 10-3 will be used mostly towards underprivileged women addicted to illicit drugs. Women addicted to alcohol and with a better social position are almost absent from the statistics of closed ward treatment (Hansen & Svenkerud 2006).

The study reported by Söderström (2011) found that the women were motivated for treatment and firm limits, but not necessarily under conditions of coercion and not in isolation from partners and a supporting network. They wanted to protect the foetus through a drug-free pregnancy, but they also acknowledged the need for varying degrees of firmness against the pull of addiction. Although severe addiction influences cognition, decisional processes and willpower, the strong

motivation to change and heal in this particular phase of life must be carefully invested in. We suggest that the interventions targeted at pregnant addicted women must be developed according to a wider range of needs and with greater emphasis on voluntariness. The most productive approach, in our view, is one where the professionals strongly align with the parents' motivation to change. Within a respectful relationship, the need for firm limits can become concrete in terms of a degree of control and procedures for overriding the women's decisions, when these are a threat to foetal development. In a joint strategy to protect the foetus, the professionals can move away from the guardian position of better knowledge and distrust of the woman to empowering relationships based on shared knowledge, trust and respect.

Women with addiction often feel weak, stigmatised and in lack of control, and they carry a load of humiliating and disempowering relational experiences (Murphy & Rosenbaum 1999). To counteract this, the path towards responsible parenthood must be paved with relational experiences that enhance respect, trust, reflectivity, affective awareness and a sense of agency. The framework of relational ethics seems particularly helpful in families at risk where safeguarding the developmental conditions for the child must be combined with a benign relationship with the parent(s). A family-oriented rehabilitation also requires increased attention to the treatment needs of the father-to-be as well as the joint transition from partners to parents (Cowan & Cowan 2005).

Stevens and colleagues (2006) argue that intrinsic motivation can develop alongside external motivation and over the course of treatment. Söderström (2011) found that women to some degree accepted coercion as help to resist the strong pull of the substances "out there". It gave a necessary pause from the drug scene and forced them to think things over. In hindsight some expressed gratitude for the assistance to protect the foetus. Thus, loss of autonomy and feeling weak can change into feeling better about it later. The women also referred to relational experiences that made coercion and surveillance easier to endure. This indicates that coercion can be justified in the rehabilitation process, given that it is done in a respectful way. This leads us to the relational aspect of ethical awareness.

Marcellus (2004) argues that a purely principle-based ethics have shortcomings in health and social work with families at risk. The bio-ethical framework gives little attention to the content and dynamics of the relationship. Relational understandings de-emphasise independence and facilitate well-nuanced distinctions between forms of clinical communication that support and that undermine patients' autonomy (Entwistle et al. 2010). The experience of coercion and/or surveillance will vary along the quality of the relationship between client and professional. Although difficult, trust can develop in an engaged and mutually respectful relationship (Marcellus 2004). Respect is based on the effort to understand the other's experience and circumstances. But understanding the other is not enough. The professionals must also be self-reflective and attentive to how their own mental states, actions and the power imbalance may influence the relationship. This is similar to what Allen, Fonagy and Bateman (2008) call a mentalising attitude in social interaction,

that is, a heightened attention to the role of the underlying mental states and trying to understand the other from the inside and oneself from the outside. Relational ethics provides a framework in which professional practice requires engagement, respect and "an exquisite sense of balance and a finely developed sensitivity" to the many factors that play into each situation (Oberle & Tenove 2000).

That many of the women in question have experienced humiliation and dignity violations demands "a finely developed sensitivity" in the professional. Within the framework of relational ethics, every encounter with the addicted pregnant woman is an interpersonal experience with potential to build trust and reflectivity, or to disempower and inflict relational harm. Elements of the admission process in the cases of Anna and Siri fall into the category of disempowerment and relational harm, which poses an additional challenge on the clinic to restore trust. "The one who is very strong, must also be very kind" (Volden 2009, 1182). The citation refers to the welfare state apparatus and the power of professionals to define and make decisions on behalf of weak patient groups.

The case material is used to identify ethical dilemmas. We do not attempt to answer whether the negative experiences from § 10-3 interventions can be justified by the outcomes. Such an evaluation is much needed, but requires a different methodology and sample. However, to sum up the discussion we share some reflections on the pros and cons of § 10-3. The major pro argument is foetal protection. We sympathise with the focus to ensure the best possible health to the future child. In relation to the pregnant women, we see the need for firmness against the pull of addiction. The addicted woman may benefit from being held back against her will when she is unable to resist taking drugs by own willpower only. Some women expressed gratitude when looking back despite hardships during the § 10-3 regime (Söderström 2011). The cons are related to the negative effects, that fear of incarceration may lead to avoidance in seeking antenatal care, and in some cases even to termination of pregnancy.

The credibility of the paragraph is at stake as long as it primarily targets illicit drug-using women but only very few pregnant women with alcohol addiction. We fear that § 10-3 can be used as power tactics or as a punitive reaction against women who do not comply with professional evaluations. We also worry that the threat of losing custody may lead to quasi-compliance and surface adaptation based on reading the cues of the professionals rather than developing sensitivity to the baby in a safe and holding environment. The experience of being a container for as healthy an infant as possible must be counteracted by an equal aim, not a secondary, to promote maternal well-being and development as caregiver. In a larger perspective, this can only be achieved through rehabilitation and promotion self-worth, hope, agency and integration in society.

Based on these reflections, we argue that a tendency to see the best interest of the foetus and the pregnant woman as contradictory strains the professional helping relationship and may influence the psychological preparation for motherhood negatively. A replacement of the hierarchy

of aims in § 10-3 with an equal aim of protecting the foetus and promoting caregiving competence could be one small, but important change in the existing social services legislation in Norway.

Conclusion

The Norwegian § 10-3 prioritises foetal health and development before the woman's autonomy. This clear aim makes it relatively easy for professionals to implement the paragraph. Although based on good intentions, there is ample evidence that mandatory interventions within a paternalistic frame may result in infringements. In this article, we propose an alternative perspective in which the protection of the foetus and the promotion of the rights and needs of the woman are seen as two sides of the same coin. However, the balancing act between needs and rights requires an elevated professional reflexivity, interpersonal sensitivity and relational competence beyond a principles-based ethical framework. The framework of a relational ethics provides a promising supplement. This case-based discussion is concluded with a call for further evaluations on the consequences of § 10-3, preferably in comparison with voluntary interventions with intensive professional support. The differences in Nordic legislation lead to different models of interventions. This makes comparative research between the Nordic countries particularly interesting.

Declaration of Interest None.

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NOTE

1 Referring to § 10-3 in the new Municipal Health and Care Services Act (Helse- og sosialtjenesteloven) which replaced the § 6-2a from January 1st 2012.

Norwegian Municipal Health and Care Services act § 10-3. Detention of pregnant substance abusers

It can be decided that a pregnant substance abuser without her own consent shall be admitted to an institution appointed by a regional health enterprise, cf. Act no. 61 of 7 July 1999 on specialized health care, section 2-1a second sub-paragraph, and be held there for the rest of the pregnancy if the abuse is of such a nature that it is most likely that the child will be born with injuries, and if voluntary measures according to section 6-1 are insufficient. The County Board shall simultaneously decide whether the institution shall be permitted to take urine samples from the pregnant individual during the incarceration.

The aim of the incarceration is to prevent or minimize the likelihood of injuries to the child. During the incarceration attention shall be paid to providing the woman with satisfactory help for her substance abuse and to enable her to take care of the child.

Social services shall, in cooperation with the institution, at least every third month readdress whether there are still grounds for detention. The detention can only continue if social ser-

vices make a decision within this time limit.

Social services can refrain from implementing a decision if the circumstances so indicate. If the decision is not carried out within two weeks, it lapses.

A temporary decision according to the first sub-paragraph can be made by social services where it may be seriously detrimental to the interests the provision is intended to serve if a decision is not made and carried out at once. For that matter applies the procedures laid down in the Child Care Act section 7-22 and 7-23.

If a temporary decision has been made, a request for a final decision shall be sent to the County Board within two weeks. If the case is not forwarded to the County Board within this time limit, the decision lapses.

Translation by Søvig (2011) based on the § 6-2a-version.

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