Caught Pregnant:

Wresting and Relinquishing Control Over Motherhood

In Manchester UK

Abigail Edgecliffe-Johnson
Abstract

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Popular portrayals of drug-using mothers claim that they are just “not into mothering” or that they leave their children to “fend for themselves” in their relentless pursuit of their own pleasures. Yet a deeper reading of these statements, and others like them reveals that they are not simply a judgment on this specific group of deviant women, but form part of a continuum of strictures informing all women about what is expected of them as women and as mothers. They lay the foundation for the enforcement of particular modes of behavior for women, for pregnant patients and for mothers.

In an attempt to explore how the cultural imperatives of mothering are influenced by the cultural strictures against drug use and drug users, this ethnography explored the lives of 14 drug-using mothers in the comparatively supportive environment of Manchester in the United Kingdom.

Over the course of three years of fieldwork and in-depth interviewing two major themes emerged: Control and Fluidity. Control was most apparent in the persistent tension between the women’s self-imposed need for control (over her body, her children, her drugs and herself) and the control both demanded and imposed by the state agencies that work with her. Fluidity, particularly of the mothering identity, quickly emerged as a key aspect of women’s lives and their understanding of self. Drug-using mothers are criticized for supposedly violating the bonds of the mother-child relationship, but the
bonds are already frayed by a system that forces them to confront the possibility of child loss before the child is even born.

To capture the shifts in meaning and experience of motherhood for this population I developed a descriptive model that categorizes their experience of the mothering identity through the filter of child-loss: The Conspicuous Mother, The Latent Mother and The Abnegate Mother. The model shows that child-loss is not an all-or-nothing experience for these women, and goes some way toward understanding why, when some women lose their children they “go off the rails” while others use child loss as an opportunity for getting their lives back on track. The study also makes clear that in order to create sustainable change we must move beyond the notion that drug-use invariably leads to neglect and focus instead on creating systemic change in the women’s lives, not just their drug-taking.
# Table of Contents

Mothers, Monsters and Manchester .......................................................... 1

The Drug Problem ..................................................................................... 51

Caught Pregnant ....................................................................................... 89

Trial and Error and a Lot of Heartache ..................................................... 152

  Table 1 - Children in the Care of: .......................................................... 175

Under Control .......................................................................................... 207

Bibliography ............................................................................................ 234
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For Amelia and Asher
Mothers, Monsters and Manchester

Here is a deep dark secret about drug addiction: It is phenomenally boring. Ripping and running, Breaking Bad, Thug Life etc., all sound terrible exciting, if not downright glamorous in their way. But the daily grind of drug use can be as exhilarating as working in a button factory. Once you’ve acquired a heroin habit, for example, you wake up every day feeling dreadful; like morning sickness without the added bonus of pregnancy hair. In order to feel normal you need your heroin. If you don’t have any to hand you need to go get it, but first you need cash. In Manchester, England, the locus of this study, if it’s a Monday, you may be getting your GIRO (or benefit check). But if that money has run out, you’ll need to borrow some from a friend, or go to work. For many problematic users, work means shoplifting. If you are good, shoplifting can net up to a £1000 a day, but you’ll still need to find someone to buy it from you which means waiting around until your connections show up. Now that you’ve got your money you need to get a hold of the drugs. For some users, (typically the non-veteran who hasn’t worked out their supply network yet) that can mean waiting on a street corner for several more hours until the dealer shows up. Then, once you’ve used and you have a few hours of feeling normal, possibly even good, you get to start the whole thing all over again. Exhilarating. No?

Many of the users I spoke with shoplifted to order. They would target specific retailers and only lift certain high-end goods like designer handbags, perfume and other luxury goods, for which they already had a buyer in mind.
For drug-using mothers, they must combine the demanding work of being a user with the full-time work of childcare. It is a difficult juggling act, but as I hope to show through this research, not altogether different from the juggling all mothers do. Yet media reports of drug users, and drug-using mothers in particular, would have us believe that they lead a life of hedonism and wild abandon to the exclusion of all else.

“They spent the early years of the children's lives focused only on getting drugs and getting high. And while they and a host of strangers sat in the kitchen shooting up heroin and smoking crack, the children - at the time just 3 and 6 - had to fend for themselves.”

_Troubled lives: one family’s story of chaos and redemption._ Channel 4 News UK, December 15, 2011 (channel4.com)

“Crystal meth…has become the drug of choice for bored American housewives since it became popular among bikers and in gay clubs a decade ago. So far in this country, it has been aimed mostly at the London gay scene - where its qualities as a raging stimulant and disinhibitor encourage sexual marathons.”


“Ms. Rubin was happy to let her daughters go. ‘It was less of a headache,’ she said, pausing. Tears welled up. ‘It was less money I would have to spend taking care of my children and more money to get high.’ She had given up on being a mother. There would be no more bedtime hugs, shopping trips or meals to cook in their Brooklyn home. ‘They were upset, they were hurt,’ she remembered. ‘My kids loved me unconditionally, but it wasn't enough to stop at that time.' Her only love at the time was the desire to experience the euphoria from the first time she got high.”


"With these babies, we are finding they are not being talked to, stimulated, because mom is too busy taking care of her business, drugs and whatever. She is not into mothering.”
In the articles above, drug-using mothers have “given up on mothering” or are just “not into mothering.” In pursuing their own pleasures the mothers have left the children to “fend for themselves.” These descriptions appear intended to evoke sympathy for the neglected children and outraged horror at the selfishness of the mothers. Yet a deeper reading of these statements, and others like them reveals that they are not simply a judgment on this specific group of deviant women, but form part of a continuum of strictures informing all women about what is expected of them as women and as mothers, and what the penalties are if they fail. The descriptions of these monster mothers (to borrow a phrase from Anna Lowenhaupt Tsing) are not only formed by, but are also active in forming, our articulations of all ‘good’ and ‘bad’ mothers. They lay the foundation for the enforcement of particular modes of behavior for women, for pregnant patients and for mothers.

However, before we can explore how this particular group of monster mothers came into being, we must re-establish the mythical status of the “crack baby.” Though debunked for over a decade, the crack baby myth endures because it is a compelling narrative. Good, embodied by the innocent child, is pitted against evil, embodied by the hedonistic woman whose pursuit of pleasure has led her to abandon her “proper” feminine role. Echoed here too is a variation of the classic virgin-whore dichotomy. Women must strive for the purity of the Virgin, capable of bringing forth God, or risk being equated with Grendel’s nameless mother, living literally outside of civilization and its constrains, bringing forth a monster. The monstrous “crack baby,” portrayed as a
threat to the moral, social and economic fabric of society, paved the way for current legislation and policy for and about drug-using pregnant women. As will be explored further below, it had its origins in long held beliefs about the status of women and, particularly, in the role of medicine in shaping and enforcing those beliefs.

Although “crack-moms” were primarily a US phenomenon and this study takes place in the UK, there is sufficient overlap and cross-pollination between ideologies in both US and UK contexts to make it possible to discuss the developments concurrently. Just as television shows have crossed between the two countries, so have moral panics, medical developments, and policy ideas. And, just as TV shows get remade with local actors, ideologies of drug use and mothering remain recognizably the same, but culturally distinct.

What is compelling is the idea that a woman who ingests bad things during her pregnancy is condemned as a bad mother. It is assumed that putting bad things into her body during pregnancy is proof that she will inevitably do bad things to her child. Yet, the definition of a substance’s badness is so culturally and historically specific that it gives the lie to the idea that it is the fetal “harm” alone for which a woman is being condemned.

It was pregnant drug-users (specifically poor, black, crack-using women in the US) who were unwittingly launched into the public imagination as the premier symbol of modern debased motherhood. Their particular form of deviance was seen as a threat to

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2 Ideological cross-pollination between the two counties is nothing new. A Jacobean era law from Britain that criminalized the death of a ‘bastard’ infant born without witnesses (the presumption being that the mother killed the child to hide a shameful pregnancy) was adopted verbatim in the US in the 1690’s. (Tsing, A. L. 1990 Monster Stories: Women Charged With Perinatal Endangerment. In Uncertain Terms: Negotiating Gender in American Culture F. Gingsburg and A.L. Tsing, eds. Pp. 282-299. Boston: Beacon Press.)

3 Though as Campbell points out, there have been other women and other drugs used as similar symbols in other eras. (Campbell, N. D.)
the wider social order and even to the US economy itself. The responses (both popular and policy) to the “crack-baby epidemic” were grounded in bad science and fueled by poorly disguised racism (Small 2001; Springer 2010), yet their legacy endures. With each new drug there is an attempt to create a new damaged-baby scare (Meth Babies, Oxy Babies and the like) and crown a new queen of deviance. This ground has been well traversed elsewhere (Boyd 1999; Boyd 2004; Flavin and Paltrow 2010) but it is useful to remember that drug use in pregnancy was (and still is) seen as a launch pad for a host of social ills: sick babies, who begin life as a drain on the medical and welfare systems, are said to grow up to become disruptive maladjusted children and adults who contribute nothing to society and cost everyone too much.

Crusading prosecutors, particularly in the US and Canada, contorted existing child abuse statutes to apply to the “abuse” of fetuses through prenatal drug use. Pregnant users were put in jail or mandated into (often non-existent) residential treatment programs to “protect” their fetuses from harm and, one supposes, scare the women “straight” enough to stay off drugs. Or, as one South Carolina judge put it, “I’m sick and tired of these girls having these bastard babies on crack cocaine, and until they change the law…it said I could put them in jail.” (Paltrow 1999:69). One gets the sense that it was neither maternal nor infant well-being which most concerned this judge.

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The Crack Baby Myth

Early biomedical research, primarily based in the US, made several claims of fetal harm from prenatal drug use, ranging from spontaneous abortion to physical malformations and mental retardation (Boyd 1999). However, many of those studies were flawed in their failure to exclude confounding factors like poly-drug use, tobacco use or socioeconomic factors like poverty and domestic abuse, which have an effect on fetal development. In some studies, clinicians were asked to evaluate the effects of cocaine exposure on infants whom they were told, in advance, had prenatal drug exposure, rather than using a blinded design to detect differences between exposed and unexposed babies (Chasnoff, et al. 1985; Chasnoff, et al. 1992; Volpe 1992).

We now know that many of those claims were without solid empirical foundation. In their review of at 34 well-designed studies that examined the effects of prenatal cocaine exposure, Frank and colleagues (2001) found that cocaine exposure alone was not teratogenic (i.e., did not stop cell growth) in so far as causing major fetal deformities, did not cause low birth-weight, and was not a contributor to behavior or developmental problems. However, there is some evidence that cocaine exposure is teratogenic regarding brain cell development but the long-term consequences of these changes are uncertain (Behnke, et al. 2013). More recent prospective studies have shown conflicting evidence of developmental delay between prenatally exposed, and non-exposed children. Some studies of children at 3 and 4 years of age, found few developmental differences between prenatally exposed and non-exposed preschoolers that were not confounded by other environmental factors (Behnke, et al. 2006; Chasnoff, et al. 1998; Frank, et al. 2005). Conversely Rose-Jacobs, et al. (2002) found a mild effect of prenatal exposure on
cognitive functioning in 9 to 11-year-old children, whereas Bendersky, et al. (2006) and Lewis et al. (2011) found that although cocaine exposure may affect language development, its effects are moderated by birth weight, age and gender. Importantly, in their 2002 study Rose-Jacobs et al. found that, when blinded to the pre-natal cocaine exposure status of a group of 163 four-year-olds, assessors misclassified unexposed children as exposed in 74% of cases, and exposed as unexposed in 34% of the cases.

Overall the evidence indicates that early predictions of deformities and major developmental and social delays were grossly overstated, yet confusion regarding the long term effects remains. In their recent review of the literature, Behnke states simply that “there is not a consensus regarding the effects of prenatal cocaine exposure on either long-term growth or achievement.” (2013:e1017) Even Chasnoff, the author of the earlier problematic studies, proclaimed that “the greatest impediment to cognitive development in young children is poverty” (Vogel 1997:38).

In the UK, though cannabis and cocaine use are more prevalent, more people receive treatment for heroin addiction than any other Class A drug. Long term effects of prenatal heroin use are still under investigation and its effects on brain growth and cell development are still being debated (Behnke, et al. 2013). Studies of prenatal heroin use have tended to center on effects of neonatal abstinence syndrome (NAS) or withdrawal in infancy, rather than on the developmental outcomes of prenatally exposed infants. Because heroin is relatively short acting and can cause spikes in blood flow levels, heroin withdrawal has been linked with the possibility of spontaneous abortion, although this is

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6 It would be interesting to investigate why there is this discrepancy in the research. The steady stream of studies on cocaine exposure (owing their funding to the enduring power of a moral panic) are attempting to either disprove, or prove, the original claims of harm, but there seems to be little interest in investigating the potential harms of heroin exposure, despite the fact that heroin addiction causes physiological changes in the body that are not caused by cocaine.
still a theoretical rather than clinically proven link (Hepburn 2004). For heroin, the
effects of NAS are similar to those of heroin withdrawal in adults and can include
jitteriness, irritability and hypersensitivity to light and touch (Walkinshaw, et al. 2002).
However, as Jansson and Velez point out, the scale developed to measure NAS was based
on opioid exposure alone and did not account for the effects of other prenatal factors such
as tobacco, alcohol or antidepressant use or exposure to violence, lack of prenatal care or
poor nutrition all of which can “negatively impact the pregnancy, fetus, and neonate”

Methadone, the primary treatment for heroin dependency, has been shown to
cause longer periods of NAS. However, because it does not cause the spikes in blood
levels that heroin can, it has not been linked to spontaneous abortion and is recommended
by obstetricians for use during pregnancy as a heroin substitute. There is also some
evidence that smoking can worsen NAS in women being treated with methadone, which
further complicates the ability to distinguish the effects of prenatal drug use from other
lifestyle factors (Choo, et al. 2004). As Hepburn points out, “the adverse outcomes of
pregnancy are multifactorial with deprivation...and chaotic lifestyle playing a major
etiological role” (2004:420). The few studies there are have found few developmental
differences in children prenatally exposed to heroin and non-exposed children matched
for socioeconomic status (SES) and other factors (Bandstra, et al. 2010; Berghella, et al.

In the cases of both cocaine and heroin exposure, it has been exceedingly difficult
to determine with any certainty that in utero exposure chemically predisposes the child to
drug use later in life. The confounding factors of SES, family environment, upbringing
(including any early childhood trauma) are almost impossible to disentangle from potential in utero effects.

**Risk in Context**

While there is little conclusive evidence of major lasting harm, you would be hard-pressed to argue that cocaine or heroin is *good* for a growing fetus. However, the construction of prenatal drug use as a major social problem is disproportionate to any particular biological effects on the fetus. It is exceedingly difficult to uncouple a drug’s social badness from its physiological badness. Because in the 1980’s crack was seen to be a “bad drug” associated with a “bad” (and therefore undeserving) group of people, it was seen as uniquely harmful to the fetus. Whereas when (white) people “freebased” cocaine ten years earlier by mixing it with baking soda and smoking it – precisely the same thing as smoking crack – pregnancy rarely entered into the conversation (Campbell 2000).

Tobacco is potentially harmful to a fetus and is far more widely used than illicit drugs, but it is the legal status and not the chemical composition of tobacco that protects pregnant users from losing their children to social services. Of course smokers are upbraided for their use, but unlike drug users, they are not criminally prosecuted as bad *mothers*, just socially branded as bad pregnant women and bad patients.

Warnings not to use drugs during pregnancy flow from a long line of pregnancy advice aimed at helping women achieve the best possible birth outcomes. One of the many methodological advantages of being “caught pregnant” myself during my fieldwork was experiencing, first hand, the cultural variation among pregnancy prohibitions across European countries. I had previously thought that bans on foods like blue cheese and raw
sushi were universal. But while traveling in Amsterdam, I discovered that sushi is allowed because the natives eat so much pickled herring doctors feel they cannot prohibit sushi without seeming hypocritical (leaving aside for a moment the curative properties of acid on fish). In talking to French women, who are envied by every pregnant woman in England for their presumed freedom to eat soft cheeses, I discovered that salads are prohibited due to the risk of toxoplasmosis. During my tenure in the UK, the government changed its recommendations on drinking alcohol during pregnancy from one or two units (glasses, approximately) a week to none at all. Ever. Not because the science had changed, but because the government felt women were getting “confused” by the old recommendations and might decide to go on wild drinking binges, thinking it was officially sanctioned. Within each cultural context a decision has been made about what constitutes a “risk” and guidelines have been created to help women navigate those risks. The choices a woman makes, the risks she acknowledges and those she avoids, are part of her commitment not only to the future health of her child, but to her acceptance of the medical authority as it is manifested in her culture.

But medical science is continually moving the goal posts. Drugs that were once recommended are now prohibited (Thalidomide, DES). Practices that were once routine are now highly contested (episiotomy, the lithotomy position, forceps). Here’s a fun game: ask a sample of obstetricians if it is okay to eat blue cheese during pregnancy. The responses are likely to range from “Absolutely not, you and your baby will die” to “I wouldn’t risk it. Your baby might die.” But ask those same obstetricians what the risks are of having a Caesarean section and you’ll be told they are “minimal.” Major abdominal surgery, requiring the severing of tissue, the removal and subsequent
replacement of internal organs and the extraction of one living creature from another is “minimally” risky, but consuming a dairy product is potential feticide. Hyperbole not withstanding (there are risks associated with both blue cheese and C-sections), the difference in risk is the perceived ability to control one kind of risk versus another. Within the highly controlled environment of the hospital, all risks are theoretically “managed.” Outside the hospital, anything goes. Risks, particularly those that cannot be controlled, are to be avoided. Adhering to proper diet, exercise and medication regimes, are demonstrations of a woman’s compliance with these constructions of risk. As Lyerly et al., have said in their exploration of risk distortions in pregnancy, “In birth…there is an irreducible element of risk; responsible risk reasoning requires confronting the fundamental fact that the joy of birth carries with it a vulnerability to the possibility of traumatic loss.” (Lyerly, et al. 2009:40) But why is it that we have come to recognize these particular risks in pregnancy, and who was given the authority to define them?

Medical anthropologists, in whose tradition the present work follows, have explored the links between the knowledge that is created with and around our bodies through biomedical discourse and its intersection with knowledge created through broader sociocultural discourse (though the two are mutually reinforcing). As Lock explains, culture “forms systems of meanings which provide explanations of how the world works, what is thought of as ‘real’ and what is designated as ‘natural’ and inevitable” (Lock and Gordon 1988:5). Biomedical culture is no exception to this phenomenon.

What is considered a disease, its treatments and antecedents are all culturally and historically situated. Or as Atkinson states, “evidence of disease is a matter of cultural
conventions and not of invariant biological phenomenon” (1988:179) Neurasthenia, to cite one small example, was a disease prevalent in 19th century England among middle and upper class women, but has disappeared in the 21st century (Theriot 2001). Attention Deficit Hyperactivity Disorder was inconceivable in the 19th century but is diagnosed and pharmaceutically treated in over 2.7 million mostly poor, mostly male children in 21st century America7. Foucault points out that “linked as they are with conditions of existence and with the way of life of individuals, diseases vary from one period and one place to another” (1994:33), Drug use, abuse and addiction are labels that conjure different images depending on the drug being used, the location of use and the person doing the using. Morphine, given in the hospital as medicine, is a legal opiate. Morphine taken outside of medical supervision for pleasure is an illegal opiate. Heroin, once used as a treatment for morphine addiction, which was itself touted as a treatment for alcohol addiction, is an illegal street drug. But heroin can also be prescribed by a doctor, which transforms it into a legal drug. It is not coincidental that these are deemed “controlled substances.” Often the difference between illegal and legal drugs is the manner in which they are taken – i.e. for pleasure or for pain. It is the difference between Oxycontin taken on prescription for the treatment of some malady and ‘Oxy’ crushed and snorted for fun.

But what if you take opiates in a hospital and enjoy them, or you use street drugs and don’t? Does that alter the drug’s legality? Of course not, but it does alter the moral judgments we make about the user, which in turn alter the social and legal repercussions of their use. The framework of Talcott Parsons’s “sick role” can be useful in understanding the incongruity between sanctioned and unsanctioned drug use. In

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7 Centers for Disease Control, Attention-Deficit/Hyperactivity Disorder (ADHD) Data & Statistics page - http://www.cdc.gov/ncbddd/adhd/data.html
Parsons’s formulation (1951), while being sick allows one to opt-out of the requirements of daily life, it also requires that the illness be beyond an individual’s control (i.e. not self-inflicted) and entails a commitment to getting well. By using drugs after the illness has passed or outside of an illness context, the user is subverting the doctor-patient relationship as well as the fundamental underlying principle that all individuals should strive for health rather than illness. Seeking medical attention for the sole purpose of acquiring drugs for recreational, rather than therapeutic, use co-opt the doctor’s authority as a prescriber and as the arbiter of health and illness. Users of street drugs have dispensed with medical authority entirely. Drug use is acceptable only within narrowly prescribed limits. Moving beyond those limits moves one into the realm of unacceptable and ultimately illegal behavior.

There are also contradictory judgments made about users of a different social or economic status, even when the drugs are used in the same transgressive way. A stark example can be found in the discrepancy between mandatory minimum sentences for the possession (not the sale or distribution) of crack cocaine versus powdered cocaine. The infamous Rockefeller drug laws in New York State imposed a mandatory minimum sentence of 15 years to life in prison for the possession of 500 grams (slightly over a pound) of powder cocaine. In contrast, the same harsh minimum sentence was imposed for those in possession of just 5 grams (less than a quarter of an ounce) of crack, a hundred-fold difference⁸. The discrepancy had little to do with the chemical composition of the cocaine versus crack (which is roughly the same), and much more to do with the

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⁸ To put the discrepancy into starker perspective - a gram of powder cocaine can be divided into 10-20 “lines.” A gram of crack cocaine can be divided into roughly 6-7 doses or “rocks” of approximately 0.15 grams each. So 500 grams of powder is equal to between 5000 and 10,000 lines, whereas 5 grams of crack is equal to between 30-35 rocks.
presumed race (black) and class (poor) of the users of crack\(^9\) versus users of powdered cocaine and the judgments made about crime within differing populations. An influential report by Human Rights Watch found that in the US overall, blacks were 10 times as likely to be arrested and imprisoned for drug offenses as whites, even though rates of drug use among whites and blacks are roughly the same, and there are six times as many whites in the US population as blacks (Human Rights Watch 2008). Likewise, when we think of “drug users” there is a tendency to envision the street addict at constant risk of arrest and imprisonment. Yet, the drug use of rock stars and fashion models is shrugged off as the inevitable consequences of fame and fortune.\(^{10}\) In other words, there are different codes of conduct, and consequently different sanctions, for different categories of people.

Drug-using mothers sit squarely within this medical-anthropological space. While it may be tempting to assume that it is only “natural” to be horrified at maternal drug use, it is important to question not only how we define addiction and recovery (which are hotly contested terms even among those working on issues of drug use) or even which drugs have been classed as illegal, but most important, to examine why putting a particular substance into the body makes a woman a bad mother. Pregnancy in the West has come to be understood largely as a medical phenomenon in need of medical confirmation, surveillance and intervention. Drug use, on the other hand, is considered predominantly a social problem albeit one to which we have sought numerous medical solutions; from reframing the sin of inebriation as the illness of addiction, to the creation

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\(^9\) In a famous interview with Diane Sawyer in 2002 the late Whitney Houston responded to allegations of crack use by proclaiming “First of all, let's get one thing straight. Crack is cheap. I make too much money to ever smoke crack.” http://abcnnews.go.com/Entertainment/transcript-whitney-houston-im-person-life/story?id=15574357

\(^{10}\) In their financial heyday, several record companies maintained “fruit and flower” budgets, reputedly to account for the provision of illegal drugs to the hotel and dressing rooms of their more demanding stars.
of drug courts that sentence drug using offenders to mandatory treatment rather than prison. In his seminal article *Medicine as an Institution of Social Control*, the sociologist Irving Zola explains that,

> By the very acceptance of a specific behavior as an 'illness' and the definition of illness as an undesirable state, the issue becomes not whether to deal with a particular problem, but *how* and *when*. Thus the debate over homosexuality, drugs or abortion becomes focused on the degree of sickness attached to the phenomenon in question or the extent of the health risk involved. And the more principled, more perplexing, or even moral issue, of *what* freedom should an individual have over his or her own body is shunted aside. (Zola 1972:500)

In other words, by defining a phenomenon as “medical” there is an imperative to provide medical “treatment” for the “problem,” at times irrespective of the desires of the problematic individual. Medical discourse influences how we experience and comprehend both pregnancy and drug use but, equally, we must recognize that medicine’s conceptualizations of pregnancy and drug use are strongly influenced by the larger society’s framing of the role of women, their susceptibility to deviance and the social position of mothers.

Drug-using mothers are labeled “bad mothers” because of the presumed effects of illicit drugs on their child *rearing*. But those claims have little do with the lived experiences of drug using mothers and far more to do with the value judgments that are made about one group of drug users and mothers versus another. There are other mind- and mood- altering drugs prescribed overwhelmingly to women\(^\text{11}\): antidepressants (and their infamous forebear Valium) being foremost among them, which are not necessarily

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assumed to preclude mothering. Equally, as mentioned above, we cannot ignore the roles that class in the UK and both race and class in the US, play in determining who is labeled a “drug user,” and who is punished for that drug use. Poor women are overwhelmingly targeted by law enforcement and social services for investigations into their child rearing and substance use, whereas middle and upper class drug-using women more successfully avoid both scrutiny and censure. As Nancy Campbell argues in her work on drug-using mothers,

> Where disciplinary mechanisms have not worked to achieve conformity [with culturally dominant forms of behavior], White women have been "reeducated" more often than they have been criminally prosecuted. Where the pedagogical triad of education, prevention, and treatment fails, a few women (primarily poor women of color) are prosecuted in spectacular cases that recruit the public to punitive views of drug-using women.  

(Campbell 1999:919)

The drug-using mother is triply transgressive: as a user violating the law, as a woman violating her gender role, and as a patient violating medical authority. Yet the legal authority medicine asserts over women who challenge (or ignore) medical dictates has repercussions not simply for drug users or pregnant women but for mothers overall. As Carole Smart has noted, “Law and medicine…create a complex interplay in which power can be deployed from one to the other” (2002:113). Women in the US and the UK who do not obtain sufficient prenatal care (as measured by number of visits begun early enough in a pregnancy) are routinely referred to social services for investigations into their fitness to parent. The claims we make about women who fail to follow proper prenatal guidelines (on everything from diet and exercise to the nebulous directive to “avoid stress”) inevitably bleed into claims we make about those women’s fitness to
mother their children. This, despite the fact that the biological demands of gestation (a modicum of physical health\textsuperscript{12}) are in no way comparable to the demands of rearing actual children (at their most basic: nurturance, the fostering of independence, and the transmission of cultural knowledge and competency).

**The Art and Science of Childbirth**

Throughout the world, childbirth had traditionally been the preserve of female family members and lay midwives, but historians looking at the development of Cartesian rationalism and scientific thought in 17\textsuperscript{th}-century England note that it was during this time that “science and art began to take on an oppositional relationship” (Thomas 2009:126). Female Midwives fell on the art side of this divide because their practice was based on experience and oral tradition rather than the newly evolving training in anatomy and experimentation (Hanson 2004; Thomas 2009). Indeed women were largely excluded from places where such training was taking place as scientific thought became aligned with conservative social thought “which wished to keep women in a domestic, very feminine role” (Watts 2005:93). As Thomas notes, midwifery licenses in Yorkshire, England, in the late 1600’s were granted to those women who had been proven competent by other women in their community. The local churchwarden or clergyman applied for the license on behalf of the midwife, but on the recommendation of clients who had previously experienced her skill and judged her competent.\textsuperscript{13}

However, a generation later, around 1730, women’s testimonials had disappeared from

\textsuperscript{12} In the US and other Western countries there is an expectation that women to be in the peak of physical health in order to produce babies in peak physical form. Nonetheless, not all of the 7 billion people on Earth were produced under such optimum conditions.

\textsuperscript{13} Thomas notes that most midwives appeared to have only bothered to get a license under pressure from their local clergy (2009). But even this pressure to be ‘licensed’ is a significant development in the transfer of authority from the women in the local community to a larger state body in deciding who was competent to control childbirth.
licensing applications to be replaced by those of male medical professionals who had deemed themselves fit to judge a midwife’s skill. It was mother’s lack of “formal medical education [which rendered them] incapable of judging a midwife’s understanding of childbirth” (Thomas 2009:130). The battle between female midwives and *accoucheurs* or male midwives was a battle of training and sources of knowledge. Or as Hanson puts it in her cultural history of pregnancy, the disagreement turned on the relative value of knowledge gained through sympathy (i.e. the inherent ability of women to indentify and empathize with women’s experiences) versus the knowledge gained through observation (i.e. that gained through dissection, and the formal lecture based training of the medical school). Ultimately observational knowledge would win. This transfer of authority from experiential to medical knowledge, or from art to science, laid the groundwork for the modern consolidation of medical authority over childbirth in the West.

Jumping forward into the early 20\textsuperscript{th} century in the US and UK, we begin to see the development of prenatal (or antenatal) care and the medicalization not just of childbirth but also of the whole gestational period. As Barker (1998) points out in her examination of pro-prenatal care public health campaigns in early 20\textsuperscript{th}-century America, “histories of medicalization are not histories of scientific triumph *per se*. Medicine's cultural authority is not dependent on efficacy alone, but on the ability to reconceptualize a phenomenon as ‘medical’ and an acceptance of that conceptualization by the public.” Barker analyzes the public health pamphlet *Prenatal Care* produced by the US Children’s Bureau, which was distributed to over 22 million American women between 1913-1935. Reading through two editions of the pamphlet produced twenty years apart, she traces the shift from a
language encouraging “self-care” in pregnancy to one that places “continual medical supervision” at the center of the prenatal experience. She explains that

Though insufficient alone, medical rhetoric as revealed in *Prenatal Care* facilitated the medicalization of pregnancy by constituting it as disease-like, constructing the pregnant women as patient, and (thereby) pulling pregnancy into the domain of medicine. Moreover, the representation of pregnancy as biomedical gave physicians a monopoly over the ‘`knowing’” and therapeutics of pregnancy and concurrently undermined existing ways of knowing (experiential/folk wisdom).

(Barker 1998:1074)

During the same period in the UK, the man considered to be the father of modern antenatal care, Dr. John Ballantyne, working out of Edinburgh, Scotland, began to put forward the notion of “Pro-maternity” care (in this case “Pro” means before or ante, rather than in support of). Ballantyne’s objective was at first to understand and treat ‘morbid’ pregnancies, or those of women made very ill in pregnancy, with the aim of improving infant health via an improvement of maternal health. He was insisting that “Mothers obey the laws of ‘gestational therapeutics’.” Even while admitting medicine’s “imperfect” understanding of the prenatal period (Oakley 1984:257). But the antenatal care of the time was more akin to welfare than medicine in that it advocated the provision of “good food, healthy surroundings and avoidance of excitement” (Oakley 1984:51). This is unsurprising as during the early 20th century in England there was overall concern for the declining health of the population, suspected to be due to industrialization, which would culminate in the provision of the National Insurance Act of 1911, a precursor to the National Health Service. Importantly, Ballantyne’s focus on the health of the fetus, rather than the mother, paved the way for a shift away from the “golden rule” of obstetric
care, outlined by the male midwife William Smellie in 1752: “The mother’s life is always to be more regarded than the safety of the child” (Hanson 2004:8).

While it might be tempting to argue that prenatal care was critical in the lowering of maternal mortality rates, Barker argues that “20th century reductions in maternal mortality are almost entirely attributable to the elimination of postpartum infection and hence related to delivery practices … not prenatal care,” as the fall in mortality rates precedes the widespread use of prenatal care (Barker 1998:1068). There is a particular irony here as a large proportion of those postpartum infections or puerperal fevers were due to physician (rather than midwife) intervention into childbirth, as physicians literally carried on their unwashed hands the diseases of their general practice patients into the wombs of birthing women (Oakley 1984). Medicine did not take authority over childbirth due to its superior understanding but rather its superior organization (Starr 1982).

Concurrent with the development of antenatal care was the emergence of medicalized, rather than cultural or religious, understanding not just of women’s bodies but of their ‘true natures.” During the industrial revolution in the US and the UK, the locus of work and production had moved from the home to the factory, which forced women and children into a ‘sacred sphere’ of hitherto unknown idle “domesticity” (Ehrenreich and English 1978; Oakley 1984; Rich 1976:49). A byproduct of this separation of work and home was the establishment of home as the anti-factory. Women, through their roles as nurturing mothers and obedient wives, were meant to embody the qualities of safety, security and tranquility. The home was meant to provide a bulwark against the dehumanizing and atomizing effects of the factory. When middle class women, who were at once the primary targets and guardians of these cultural values,
began developing a host of “medical” conditions like neurasthenia and hysteria, physicians located the source of their “nervous” problems in women’s refusal to accept their “natural” social roles. Theriot, studying the collaboration between doctors and patients in the creation of disease categories in 19\textsuperscript{th} century England notes,

\begin{quote}
Nineteenth-century physicians argued that women’s roles in family and society were determined by female reproductive functions. Scientific writing about the uterus and ovaries reinforced the widely held view that woman’s nature was domestic and maternal and that women’s work should be confined to kitchen and nursery. Menstruation, pregnancy, childbirth, lactation, and menopause were described by nineteenth-century doctors as defining women’s life possibilities.
\end{quote}

(Theriot 2001:350)

As the feminist legal historian Carol Smart has noted, women’s bodies are routinely “used as a point of entry for social values and norms” (Smart 2002:113). The difference in modern times is the use of medical authority to enforce those values. Similarly, writing about the way post-menopausal women have been conceptualized by the medical literature as unnatural artifacts of the modern age, Margaret Lock writes that “the medicalized body, … is at the same time a manifestation of potent, never settled, partially disguised, political contests that contribute to the way in which the female body is ‘seen’ and interpreted” (Lock 1993:331) In situating women’s social roles within supposedly biological origins, the scientific expert made it his (they were mostly male) business “not to seek out what [was] true but to pronounce on what [was] appropriate” (Ehrenreich and English 1978:28). In other words, the medical community vested in itself the power to not only define femininity but to enforce it. Medicine’s solution to women’s discomfiture with this new role was to ensure that women comply with their ‘true’
feminine natures. A nature that was defined as compliant, nurturing, sacrificial and selfless in the service of (again, mostly male) others. It has proved a persistent mythology.\footnote{The poet Shel Silverstein captures this perfectly in his children’s book \textit{The Giving Tree}. A boy/son, is endlessly nurtured by the tree/mother who gives him security, food and shelter to the point of her own destruction, at the end offering him the only thing she has left, her own dead stump, to rest upon when he is finally old and weary himself. I have always loathed this hugely popular book.}

Ehrenreich and English, in their history of the medical care of women, found that the rise of psychiatry coupled with the discovery of hormones in the 1920’s, which provided a link between the emotional and the physical, gave gynecologists in particular a “claim to the female psyche as a terrain for intervention and investigation.”

Gynecologists undertook this new role with such gusto that they almost “abandoned the female reproductive organs in their haste to pass judgments on the female psyche” (1978:275). Dr. Haig Ferguson, an obstetrician and disciple of Ballantyne’s, even “advocated the restriction of girls’” education on the grounds that it “injured their pelvic organs” (Oakley 1984:51). As recently as 1962 a gynecological text was training physicians that “much of the physical and mental ill health of the individual woman can be properly understood only in the light of her conscious or unconscious acceptance of her feminine role” (quoted in Ehrenreich and English 1978:276).

When women tried to resist the hypermedicalization of childbirth that had all but removed them from the process through the use of twilight sleep, forceps, induced labor and epidurals, their non-compliance was proclaimed a disease in and of itself. A gynecological textbook from 1965 claimed that in a woman who demanded natural childbirth “the intensity of her demands and her uncompromising attitude on the subject are danger signals, frequently indicating severe pathology…a patient of this sort is not a
candidate for natural childbirth and requires close and constant psychiatric support.”¹⁵ (Asch 1965 in Ehrenreich and English 1978:278, original emphasis). Though attitudes toward natural childbirth have changed, the conflation of a woman’s biological possibilities with her social responsibilities has endured.

As Oaks discovered in her study on smoking in pregnancy, women who fail to adhere to “expert guidance” are deemed to be “weak willed, selfish and immoral risk takers who threaten the social order and well being of future generations.” (Oaks 2001:5). Anna Lowenhaupt Tsing’s study of women prosecuted for fetal endangerment showed that women who do not use prenatal services are cast as “stupid, lazy and irresponsible” and while those traits may be reprehensible in anyone “it is seen as criminal to operate with these traits around children” (1990:294 original emphasis).

This characterization can be understood through the anthropologist Barbara Koenig’s concept of a “moral imperative” to use the latest medical technologies as they become available. She argues that as new technologies of care are developed, they move rapidly (though not always smoothly) from the experimental to the routine. Physicians, working within a biomedical culture that judges the “best” care to be the newest and most technologically advanced, are faced with an imperative to use the new “standard” of care. Even when there is conflicting evidence of a technology’s clinical efficacy, it is almost impossible not to use it because it violates the “technological imperative” of newer is better (Koenig 1988:466). Prenatal care, and the surveillance technologies that have developed alongside it, represent an extension of the moral imperative from doctors to

¹⁵ This runs in stark contrast to the position of the Catholic Church, which was so horrified at the idea of anesthesia in childbirth (to relieve the curse of Eve’s transgressions), that the Church linked it to inevitable moral decay in the whole of society (Rich 1995, pg 168).
Women who attempt to opt-out of these technologies are seen to be opting into backward, outmoded ways of thinking and are by extension to be backward themselves.

Elizabeth Armstrong, in her study of the “discovery” of fetal alcohol syndrome in the 1970’s (2003), identifies some of the elements that would eventually lead to the demonization/criminalization of drug-using mothers. Linking the thalidomide tragedies in Europe and a small but dramatic rubella outbreak\(^{16}\) among pregnant women in the US to the growing awareness of environmental toxins worldwide, Armstrong notes that the early 1960’s and 1970’s were a time of heightened awareness and fear of a “poisoned environment” both from within and without. Highly publicized accounts of babies born severely deformed or disabled as a result of pre-natal exposure to harmful substances or organisms shattered the assumption that the womb as a uniquely protected space. In its place was created the image of the womb as a permeable, fragile container of even more fragile contents (Armstrong 2003:190). Medicine developed a series of prescriptions and proscriptions for prenatal (and even pre-conception) behavior designed to protect these newly vulnerable creatures. Those who fail to protect the vulnerable are vilified.

But, as Tsing has said, the concept of “perinatal vigilance,” which demands that women attempt to control all aspects of their, and by extension the fetuses’, environments “requires that pregnancy be a transcendent moment that can carry every woman outside of the complexity of her particular history” (1990:297). In other words, while pregnant, women are expected to live an ideal life, regardless of the conditions of their ordinary workaday lives. Returning to the Prenatal Care pamphlets from the early 20\(^{th}\) century, Barker points out that the biomedical advice given centered “on bourgeois notions of womanhood in which activities are disentangled from tasks.” Women were told to avoid

\(^{16}\) Rubella exposure in the first 16 weeks of pregnancy can cause severe disabilities in the developing fetus.
all work or anything that might be too demanding or taxing in order to achieve a good birth. Barker continues, “the advice is given as if bourgeois class privilege could be extended to all women” (1998:1072) but clearly, most women could not afford to give up all “taxing” work for the better part of a year and still be expected to have enough money to feed themselves and their children.

For drug-using women, this expectation of transcendence poses an acute problem. They fail as patients for not complying with doctor’s orders (a term which itself hints at the military-esque authority we have granted them over our bodies) through their use of illegal substances, and they fail as women and mothers for not living up to the self-sacrificial ideal. Several authors have traced the history of drug use and its eventual criminalization, (see Davenport-Hines 2002 for a lively global history of drug use) but what becomes apparent is that in each epoch there is a conflation of a drug’s physical effects with its supposed effects on morality in general and on women’s sexuality in particular (Campbell 2000). Whether it was the gin craze of the 1700’s, the opium scare of the late 1800’s or the crack epidemic of the 1980’s, “drugs” are seen as making women “loose” and robbing them of their maternal instinct, which in turn destroys their ability to properly raise the next generation. Even feminist scholars like Cynthia Daniels have claimed that “continued drug use throughout pregnancy…must be grounds for questioning the capacity of a woman to parent.” (Daniels 1999:96).

It is not news that, in all societies, those who fail to adhere to cultural conventions are cast as deviant and risk being cast out. Yet the peculiar status of pregnancy, enfolding as it does the issues of health, personhood, bodily integrity, human rights, privacy and the

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17 Since mothers are meant to be sacrificial and sex is meant to be an indulgence, sexual promiscuity is invariably cast as anathema to maternal fitness.
social status of women (to name a few) leaves pregnant women particularly vulnerable to accusations of deviance. Critically, reproduction is “laden with social and economic meanings” (Hanson 2004) for individuals as well as for larger state actors, which means that a woman can never know for which behaviors she may be sanctioned or by whom. A striking example is given by Lynn Paltrow of the National Advocates for Pregnant Women about a woman who was, in effect, murdered for the symbolic value of her fetus. Angela Carter was a cancer survivor who became pregnant after 3 years in remission. Throughout her pregnancy she stressed to her team of obstetricians that “having struggled so long to survive, she wanted to be sure her own health was not compromised because of her pregnancy.” When she was 25 weeks pregnant she was diagnosed as having a lung tumor, which she and her doctors decided to treat with chemotherapy and radiation despite the risk to her fetus. However, before she could receive treatment, her condition deteriorated “depriving Angela and the fetus of substantial amounts of vital oxygen for many hours.” Her doctors, knowing Angela’s wishes regarding her treatment and her will to live, did not attempt to deliver her fetus. The next morning though, the hospital’s administrators disagreed with this decision and sought a court order to determine whether or not to “rescue” the fetus. To cut a long and sad story short, Angela, her family and her team of doctors lost the hearing. The court ordered her to undergo a cesarean section despite the clear risk to her life.

“When her doctor explained that she might die as a result of the ordered surgery and that he would not perform the surgery without her consent, she said repeatedly, ‘I don't want it done.’ However, this declaration did not sway the hospital to withdraw its petition or the court to amend its order. A three-judge appellate panel upheld the decision during an emergency telephone appeal. Minutes later, having just been told that she probably would not survive the surgery, the woman who had courageously cheated death for
fourteen years was rolled into the operating room. The fetus died within two hours. Two days later, Angela Carder died, never having received the cancer treatment she requested.” (Thornton and Paltrow 1991)

In this case, a woman put herself under medical control only to be thwarted by legal controls which placed the value of a potential life above that of an actual life. The result took the cultural expectations of maternal sacrifice to their logical and deadly conclusion.

So, how do we uncouple the fact that consuming illegal drugs is not beneficial during pregnancy from the excessive moralization that seeks to put pregnant women in jail and remove their maternal rights because they use drugs? There are other behaviors similar to drug use that can both harm the individual woman and potentially harm the fetus, but these are not criminalized or demonized in the same way.

For instance, obesity, like drug use, is a disease of excess. While there may be genetic and socioeconomic factors that predispose someone to gain weight (as these same factors have been hypothesized to make some more prone to addiction than others) it is not unreasonable to class obesity, like drug use, as a self-inflicted disease. Rates of obesity in the US and UK are approximately 33% and 22% respectively\(^{18}\), comparatively, rates of illegal drug use are approximately 8% in both the US and the UK\(^{19}\). Obesity can lead to gestational diabetes, which has been shown to cause stillbirth, malformations, and overweight babies who are in turn at higher risk for obesity and diabetes themselves. And yet there is no ‘Fat Baby Epidemic’ splashed across the headlines. We would think it absurd to put obese pregnant women in jail for child abuse, or to force women to have gastric band surgery to protect the life of their fetuses. We do not assume that fat women


make bad mothers because they ‘refuse’ to sacrifice for their children or fail to control their eating habits. Though, given the attempts to criminalize other aspects of pregnant women’s behaviors, one can envision a time where this becomes possible.

To argue that it is the illegality alone that makes a user of a particular substance a ‘bad mother’ ignores the reality of the ever-shrinking list of behaviors pregnant women are allowed and fails to recognize that those behaviors are culturally determined. Conceptualizations of ‘risk’ in pregnancy are fluid, changing with the technologies that make new assessments possible, and even with location, as some cultures fear Caesar salads more than Cesarean sections. But the use of a risk framework “consolidates medical professionals’ power over pregnant women” and “extends beyond the medical world into the legal” (Oaks 2001:13). As Lynn Paltrow, head of the National Advocates for Pregnant Women has outlined, “when medical advice dictates legal rights, all women’s autonomy is severely restricted” (Center for Reproductive Law and Policy 1996 paraphrased in Oaks 2001:180). In addition to the prosecutions of pregnant drug users in the US, there have been attempts, some successful, to criminally prosecute other women whose babies were born imperfect. Searching for a post-hoc justification for this unimaginable outcome, prosecutors accused these women of causing harm to the fetus through such everyday activities as having sex or going to work (Oaks 2001).

Doctors like to joke that a ‘normal’ pregnancy is a retrospective diagnosis. In other words, everything about the process of reproduction is uncertain. Until it is all over,

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20 To be clear, obese people face a host of stigma all their own, but it is presumptions about maternal fitness that are at issue here.

21 This trend may have already begun. In November of 2011, a child in Ohio was taken from his mother and placed in foster care because “his mother’s inability to reduce his weight” was considered by the state to constitute “medical neglect.” Within this framework, one can envision a time where the prosecution of obese pregnancies becomes possible. (TheWashingtonPost.com, November 27th, ‘Severely obese’ Ohio third-grader taken from family and put into foster care. retrieved December 5th, 2011)
and you can test the baby, measure the head circumference and weight gained, you
cannot “know” that everything is normal (or rather, that everything turned out in
accordance with accepted definitions of normality). If the baby is born well, the mother
has done her job. If the baby is born imperfect, the whole history of her pregnancy will be
examined to uncover what risks she took that ‘caused’ the infirmity. But as Oaks (2001)
explains in her study of smoking and pregnancy, you cannot “individualize risk.” You
cannot use the generalized risk of getting into a car accident to predict with any certainty
that this individual woman will get into that particular car accident. At some stage one
has to accept that any action entails risk. Whether it is walking down a flight of stairs or
getting into a car, there are risks inherent in everyday life. Yet, when a woman is
pregnant, she is expected to behave as though an individual calculation is possible. The
specter of risk, and her duty to avoid it, follows her throughout her pregnancy. As Ann
Oakley (1992) has noted, the quantification of the infant body is connected to judgments
about the mother’s role in ensuring the baby’s normality. As Landsman (1998:96) points
out in her study of mothers of disabled children “less than perfect children are [seen as]
the justifiable outcome of an individual’s less-than-perfect choices.” Those who fail to
produce perfection are somehow at fault.

So how do we get from imperfect choices to criminal ones? How is it that a
failure to engage with the production of perfection can result, as it has, in criminal
sanctions? Scholars from disciplines as varied as history, anthropology and feminism (to
name a few) have long made explicit that the rise of the medicalized pregnancy is the rise
of reproduction as production; of the baby as a product (See Emily Martin, Rayna Rapp,
Robbie Davis-Floyd). The narrative of production implies that we have control over the
process; that proper diet, exercise and even mental attitude are required to achieve optimal fetal growth. The rise of antenatal care and the technologies that enable *in utero* surveillance of the fetus hold out the possibility that we can produce “perfect” babies. Yet it is important to remember that although this shift has come with the rise of medical technologies, it has flourished with the cooperation of women and their families.

Because, as Karen Michaelson and others have argued, each individual child is more precious to the family it must be “‘worth it’ in terms of its potential for a full and emotionally gratifying life.” Michaelson, in the introduction to a collection of essays on childbirth practices in America, links the rise of the precious child to the decrease in family size, as post-industrialization era children became “economically ‘worthless’ but emotionally ‘priceless’” (Michaelson 1988:15). This is not to say that previously life was cheap, but that the effect of one damaged child is perceptibly greater if it is the only child in a family rather than one of ten. In this context, Drug-using women, seemingly flaunting their non-compliance and embodiment of risk, are easy targets of censure and sanctions.

**Pregnant POW’s**

Much of the literature on drug use in pregnancy comes from the US where drug-using pregnant women are prisoners of both the “War on Drugs” and the abortion wars. In the former they are enemy combatants, in the latter they are cannon fodder.

Drug addiction is typically cast as a disease\(^22\), yet it is primarily drug users, and not drug traffickers, who are the targets of criminal prosecutions (Boyd 2004). Users, the

most visible manifestation of “The Drug Problem” in western societies, are the most vulnerable to arrest and imprisonment. Publicly funded drug treatment is scarce in much of the US and private care is financially out of reach for many users who lack insurance coverage or the money to pay for it. For women, treatment options are more limited because few programs are able to cater to their particular needs, such as substitute prescribing in pregnancy, childcare provision and gender sensitive treatment modalities that are non-confrontational and self-empowering. Drug users, maintaining the demand side of the drug supply chain, are seen as both the source and the solution to The Drug Problem.

Within the context of the abortion wars in the US, the body of the drug-using woman has been usefully dispensed with in the anti-abortion lobby’s pursuit of fetal personhood. The drug-using woman is seen as a cruel monster imprisoning the innocent ‘child’ inside her poisoned womb. She must be punished and held up as an example to prevent others from harming the innocents who must be ‘saved’ at all cost. Regardless of what that cost may be to the (drug-using) mother who, after all, is not worthy of our protection. If the anti-abortion lobby can successfully establish, in law, the harm being done to the separate ‘person’ trapped inside the drug-using mother’s womb, then it paves the way toward the ultimate goal of protection of all such ‘persons’ through the criminalizing of abortions (Paltrow 2002).

These highly charged battles make it almost impossible, in the US, to disassociate the complexities to parenting introduced by drug use, from the complexities introduced by the various ideological wars being fought around and through drug-using mothers. To attempt to increase our understanding of the lives of drug-using mothers, it becomes
necessary to seek out alternate contexts where these particular ideologies hold less sway. This research was carried out during a period of rapid growth in British, Canadian, and Australian scholarship on drug-using mothers, which can only be a welcome development. However, my piece of research takes as its starting point not the extreme stigmatization of drug-using women found by many others but the surprisingly supportive environment of Manchester England.

The Case for Looking Beyond the US

The UK, though criminalizing certain drugs, has adopted more of a “harm minimization” or “harm reduction” stance when it comes to illicit drug use than the abstinence-based approach favored in the US. In practice, this means extensive drug treatment provision, needle exchanges, and substitute prescribing options for drug users. There are hundreds of publicly funded drug treatment programs across the United Kingdom and several dozen in the Manchester area. The National Health Service (NHS) is funded by tax revenues and provides medical care to all UK residents for free.23 This means that health care, even addiction care, is available to everyone.

In addition, prison sentences (mandatory or otherwise) for drug offenses are in no way comparable to those in the US, which can be as long as 25 years. In the UK the maximum sentence for possession of a Class A drug (cocaine or heroin, for example) is seven years. From 2004 to 2009 cannabis was briefly reclassified from a Class B to a Class C drug, reducing the maximum penalty for possession from five to two years. The

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23 “Free” in this case means free at the point of service. There are no co-pays or debilitating doctor’s bills, but everyone working in the UK pays a part of his or her salary in taxes and National Insurance for the upkeep of the NHS.
aim of the downgraded classification was to “free up police time to tackle serious drug crime”\(^\text{24}\) (Home Office 2004 emphasis added).

In recent decades, there has been little or no “abortion debate” to speak of in England, Wales and Scotland.\(^\text{25}\) Abortion is available to all women up to 24 weeks of gestation and, in cases of risk to the life of the mother or serious birth defects, available beyond 24 weeks. The drive to establish fetal personhood has not yet begun\(^\text{26}\); therefore, neither has the drive to strategically demonize pregnant drug users. The combination of harm reduction approaches to drug use and a largely sidelined (though growing) anti-abortion movement, paves the way for a much more humane treatment of drug-using pregnant women.

Additionally, it is the government’s stated position that drug use does not, in and of itself, constitute *de facto* evidence of child abuse or neglect (Advisory Council on the Misuse of Drugs 2003). Therefore, a woman who uses drugs while pregnant is not, in theory, at immediate risk of having her child removed from her care. However, parental drug use *is* seen as problem in the UK. In 2003 a highly influential report by the Advisory Council on the Misuse of Drugs (ACMD), under the auspices of the Home Office, estimated that there were approximately 250,000 to 350,000 children of problem drug users in the UK (one for every problem drug user). The report, *Hidden Harm: responding to the needs of problem drug users* (2003), aimed to highlight the “previously ignored harms” to children caused by their parents’ drug use. Though the report does not seek, outwardly, to demonize drug-using parents, it takes as its starting point the assertion that

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\(^{24}\) The drug was reclassified back to Class B in 2009, ostensibly because of research linking cannabis use to schizophrenia.

\(^{25}\) Abortion is illegal in Northern Ireland.

\(^{26}\) More recently, American Pro-Life groups are beginning to expand their reach into British markets.
“parental problem drug use can and often does compromise children’s health and development at every stage from conception onwards.” It goes on to say that “[m]aternal drug use during pregnancy can seriously affect fetal growth, but assessing the impact is usually impossible, with multiple drugs being taken in various doses against a background of other unfavorable circumstances.” Similarly, the report claims that “after birth, the child may be exposed to many sustained or intermittent hazards as a result of parental problem drug use. These include poverty; physical and emotional abuse or neglect; dangerously inadequate supervision; other inappropriate parenting practices; intermittent or permanent separation; inadequate accommodation and frequent changes in residence; toxic substances in the home; interrupted or otherwise unsatisfactory education and socialization; exposure to criminal or other inappropriate adult behavior; and social isolation” (2003:10). This report, which formed the backbone of the policy response to parental drug use in the UK, outlines the multiple stigmatizing forces at work on drug-using mothers. Their drug use is seen as a cause of their poverty, poor parenting practices, bad health, and inadequate social and physical environments rather than a result of those adverse conditions.

**The Manchester Specialist Midwifery Service**

Manchester, England, has a population of approximately 498,000 and houses one of the few midwifery services aimed specifically at supporting drug-using mothers, the Manchester Specialist Midwifery Service (MSMS). Founded in 2001 by Faye Macrory, there are other similar, but unrelated, services are in Liverpool, England, and Glasgow, Scotland. Each arose independently through the dedication and determination of committed individuals (rather than from government policy initiatives): Catherine Siney in Liverpool and Mary Hepburn in Glasgow. Midwifery in the UK does not occupy the same non-conformist or “alternative” position as it does in the US. Most women in the UK will receive the majority of their pre- and post-natal care from midwives rather than from...
MSMS is jointly funded by the Manchester Drugs Service, the NHS Manchester and The Central Manchester University Hospitals Foundation Trust. The service is a non-judgmental midwifery service that supports pregnant women who are struggling with issues related to drug and alcohol use, HIV, and mental health. The service works alongside hospital- and community-based midwifery services to obtain for women the additional care they may need when dealing with the added complexities of drug use. There are two drug and alcohol specialist midwives who provide care and advice specifically around prenatal drug use, management of neonatal withdrawal, and achieving stability within the home life of the pregnant drug user. They also train practitioners (general practitioners, or GPs), nurses, obstetricians, midwives, and foster carers among others) in the effects of substance use on a fetus as well as how best to support drug-using pregnant and parenting women to achieve stability in their drug use and their lives. An important study by Chavkin et al. (1993a) identified a pressing need for drug-using pregnant women to be given advocacy and assistance in navigating the bureaucracies of the various social welfare agencies like housing, child welfare and benefits, which are vital to women’s continued recovery. The Manchester Specialist Midwifery Service does precisely this. The pregnancy outcomes for women enrolled in the service are similar to those of non-drug-using women (Boyd 2004).

Much of the prior research on drug-using mothers tacitly argues that “if only” women had access to prenatal care, drug treatment, and a supportive environment that did not put them in constant threat of jail time and child loss, these women would be able to thrive as mothers. While I certainly would not argue that women do not need these obstetricians, as is done in the US. Most births are attended solely by midwives, with obstetricians being called in only to deal with complications. The midwives are fully integrated into the National Health Service and work both in the community and in the hospitals.
things, I do want to challenge the implicit assumption that drug treatment alone will make them better mothers. The research presented here seeks to explore the lives of drug-using mothers within a highly supportive environment. This study also looks at women’s lives as mothers beyond the prenatal period, not just at their pregnancies. Since much of the intervention into a drug-using woman’s life (medical and social) occurs when she becomes pregnant, it is not unreasonable that much of the research has focused there as well, but my hope is that in looking beyond pregnancy (though not ignoring it) we can explore the complexities drug use adds to mothering, not just to gestating.

**Recruitment of the Study Sample**

Women were recruited into the study through the MSMS. The MSMS midwives are also referred to as the Drugs Liaison midwives because they serve as a central point of contact for both the women and the professionals working with them during pregnancy. Hospital midwives, drug services, probation and social service workers all look to the midwives for best practice advice on how to best care for a drug-using woman in pregnancy and for care coordination among the services. Any number of ancillary services, from GPs, social workers, drugs workers, hospital-based midwives, health visitors, and probation officers (to name a few), have a duty to refer a pregnant woman whom they know or suspect to be using drugs to the service. MSMS also provides services inside HMP Styal, the local women’s prison, and on the Manchester Action on Street Health (MASH) van, a street-based sex worker outreach project. The specialist
midwifery service sees approximately 200 women per year, which, given the number and variety of referral sources, likely represents a high percentage of the drug-using pregnant women in the greater Manchester area.30

Women are not required to use the MSMS midwives, but they are strongly encouraged to do so. The service has an excellent reputation among drug users (both male and female) for being non-judgmental, genuinely helpful, and “safe” in that women do not see engagement with the service as a threat to their ability to keep their children (as they might with social services).

The midwives can see women in a variety of settings but most often attempt to see them in their homes, regardless of the form that “home” may take. Many of the women in the study were either homeless or awaiting better housing through the local authority. In very broad strokes, the council (local government) must decide, based on a long, but not impossible, list of criteria, whether it has a “duty to house” an individual or a family. From there the process is confusing and far from straightforward but, again broadly speaking, the council can temporarily house someone in a bed and breakfast, a hostel, or a homeless shelter/accommodation (usually a facility with individual bedrooms, but shared kitchens and bathrooms). The council then has a duty to find the (still technically homeless) person “ongoing temporary accommodation,”31 which can be in a variety of public or private tenancy settings, but all of which are paid for by the council,

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30 The total number is likely to hover around 300 drug-exposed pregnancies per year. Rates of drug use in pregnancy are estimated to be around 4% in the UK, and Manchester records approximately 7,500 live births per year. There are no official statistics on drug use in pregnancy, and these numbers clearly do not account for miscarriages, stillbirths, or terminations (ONS, Key Population and Vital Statistics 2007).

31 Temporary in this sense is a meaningless phrase because there is no time limit to how long one may remain in temporary accommodation. The term instead reflects the hope that, once given stable housing, a family or individual will be able to get their lives together sufficiently to obviate the need for council support.
with a token contribution from the tenant based on his/her income. There are waiting lists for all of the “ongoing temporary accommodations” that can be as much as three years long. In consequence, pregnant women and families with children, who get housing priority, may find themselves being moved between bed and breakfasts, hostels and other homeless accommodations as they inch up the waiting lists for a better house from the local authority.

More affluent drug-using pregnant women, perhaps the most “hidden” of so-called “hidden populations,” may have come to the attention of the MSMS through their hospital or community midwives, but because the service is voluntary, these women may not have chosen to avail themselves of it. Additionally, wealthier women would be less likely to have the range of difficulties in housing, income, health and criminality that would make them ideal candidates for the coordination services of the MSMS. Wealthier women would also have access to private, as opposed to publicly funded NHS, drug treatment, which might circumvent the need for MSMS involvement.

Thus, the study sample reflects a highly disadvantaged population. However, this is also the case because Manchester is one of the most economically deprived areas of England. It ranks fourth (with first being the most deprived) out of 326 separate districts in England on levels of income and social deprivation (including health, employment, education, housing, crime and living environment). It ranks fifth (out of 326) in terms of the extent of deprivation throughout the city compared to other districts in England.  

\[32 \text{ Indices of Multiple Deprivation 2010 Analysis for Manchester (v1.2) Corporate Research and Intelligence Chief Executive’s Department May 2011, Crown copyright 2011,} \]
Women in the study ranged in age from 19 to 42 years old. With the exception of two black women, all the women in the study identified themselves as white. Seven of the fourteen women formally interviewed were recruited during their first pregnancy while the seven others had between two and five prior pregnancies each. I was unable to get detailed pregnancy histories from those women who let me observe and chat with them but did not agree to formal interviews. However, I heard stories of repeated miscarriages, multiple children adopted away, reunification with children in foster care, and several other permutations of mothering. All of the stories and interviews were invaluable in painting a portrait of parenting under duress.

The women in the study were, or had previously been, poly-drug users. Typically, women reported that they had most recently been using a combination of heroin and crack, but three women mentioned preferring Diazepam and Temazepam. All of the women drank alcohol and three identified this as their most problematic substance (while also on a methadone maintenance program). All of the women smoked cigarettes.

**Methodology**

This study used multiple ethnographic methods, including participant observations and semi-structured formal and informal interviews, as well as textual

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33 Demographically, Manchester’s population is roughly 80% white, and 20% “ethnic and minority groups,” a category that encompasses Black, Asian, Chinese and “other.”. Although Asians (Indians, Pakistanis and Bangladeshis) represent a greater proportion of the minority population, they are significantly underrepresented in drug treatment programs and statistics. It is unclear if this is due to less drug taking in these communities or due to greater aversion to public treatment services. (Population Estimates by Experimental Ethnic Groups, Office for National Statistics. 18 May 2011)

34 In the UK, heroin and crack are typically sold as a pair. A “White and Brown” (heroin is the brown) goes for the street price of between £15 and £30, depending on the dealer. The price of a bag of heroin is fairly stable at £10, but a rock of crack varies from £10-£20 when bought singly.

35 Diazepam (Valium) and Temazepam are prescription drugs that are also traded on a thriving secondary black market. Temazepam, when used recreationally (i.e., at high doses), causes the remarkable side effect of making the user feel invisible. This has led to a number of arrests in which users have been caught red-handed trying to casually shoplift conspicuous items like wide-screen televisions or couches.
analysis of media coverage of relevant events. The study was conducted in Manchester between early 2005 and late 2007, and all interviews, observations and analysis were conducted by me. I relied on the kindness of the midwives for all of my introductions to study subjects. Though I had entertained early fantasies of snowball sampling, it soon became apparent that the women lived in relative isolation from their pregnant drug-using peers, and the few promises I did get of introductions to friends of friends never panned out. Instead, I accompanied the midwives as they met with new and established clients in their homes, on the hospital wards, in the prison or on the MASH van. Women were told in advance of my tagging along with the midwives and given the opportunity to refuse to see me.36 To all the women I met I gave a brief description of the study and asked if they would like to participate in a series of formal interviews. If they agreed, I arranged solo visits to the women in their homes to conduct the interviews. Interviews lasted anywhere from 20 minutes to two hours, depending on the topics, the woman’s mood, the raucousness of her children, or her fervent desire to get the nosy American out of her house. Women received a £20 gift card to ASDA, a Walmart-esque supermarket/department store, for their participation in each interview.

Because my home at the time was in London, three hours away from Manchester by fast train, fieldwork was conducted in one- to two-week segments every month over the three years of the study. The MSMS midwives took me with them on their rounds as they saw clients all over the city and in all manner of settings. As one might imagine, the majority of the areas the midwives and I worked in were decidedly “rough.” The midwives were quick to point out the neighborhoods where other midwives or health workers had been assaulted or places that everyone else already knew to avoid. In many

36 In these few instances, I waited in the midwives’ car, trying to look busy.
areas it was not considered safe to be out after dark, a sentiment echoed by the subjects I was working with, so fieldwork had to end by three thirty in the afternoon in the winter months when the sun set by four. As an extra precaution I also took taxis to any interview not within quick walking distance of the city center. Which, in effect meant that I took taxis to practically all of my interviews, a significant drain on a tiny research budget. Even though I met women in their homes by prior arrangement I soon discovered that that was not necessarily a guarantee that they would be there when I knocked. I learned to have the taxi wait until I’d entered a house before I’d let the driver pull away, not only for convenience in the case of no-shows, but also for the safety of a quick getaway; a serious benefit on the occasions where I found myself standing on the doorstep of a darkened house under the gaze of the local gentry.

In all, I met roughly a hundred women, took field notes on informal conversations with approximately 50 women and conducted formal interviews with fourteen (on average three interviews each) over the course of three years. Because the research was not designed as specifically longitudinal, I did not recruit all the women at the same point in the study, but rather continued to recruit women up until the final six months of the fieldwork.

Meeting women in their homes also gave me an opportunity to meet their husbands, partners, older children, mothers, extended families, and friends. Though I exchanged pleasantries with the women’s older children if they were at home, with the exception of one who was 21 years old and to whom I directed more pointed questions, most of the children were too young to make any sort of formal interview appropriate. In

37 As a native New Yorker, you learn early on to trust your instincts about a sketchy situation and not to let misguided cultural relativism get in the way of basic self-preservation.
five cases I conducted interviews with a woman and her partner together, but in many more, the interviews were conducted while “people” walked in and out of the house with seeming liberty. These people were sometimes neighbors or relatives, but often they were friends who were staying with them “just at the moment,” i.e., couch surfing. Women sometimes referred to me as their counselor to explain my presence to the friends and relatives who drifted in and out of their homes. Given the large number of service providers with whom the women interacted, a counselor, rather than a midwife or social worker, is a label of specific meaning but no significance. A counselor can be attached to any service, or no service at all, is a legitimate presence in the women’s lives, but is non-threatening for the friends and family (drug-using and otherwise) who may encounter them. By classing me as an innocuous counselor, women were protecting me by positioning me as thoroughly unobjectionable, and protecting themselves, by obviating the need to explain their role in a research project.38

There was a great similarity in the language the women and the professionals used to describe the women’s lives. Terms like “chaotic” or “stable” seemed to be mutually reinforced between the women and the professionals, so that it was difficult to discern who had adopted whose language. There were, however, moments when the language and cadence of treatment seemed to have seeped into the women’s personal narratives. In almost every initial interview with a woman, I was given a résumé of her past drug taking behaviors. This was despite the fact that I always began by asking women to describe their childhoods and family lives. It was as if they were delivering a rehearsed catalogue of symptoms for yet another specialist. It often took multiple attempts, sometimes over

38 Given that more than one woman was dealing drugs from her home, this non-threatening position was one I was happy to occupy.
multiple interviews, to move beyond the prepared statements into a more nuanced discussion of their experiences.

Women also tended to “disappear” from the study at certain points, only to reappear up to a year or two later. Distressing life events, like the loss of a partner, changes of address (both voluntary and involuntary) or temporary inconveniences like the loss of a phone, meant that women drifted in and out of contact. In these instances the ongoing help of the midwives was invaluable. Through their extended network of professional contacts, I could sometimes get details of a new address or phone number, or learn that a woman was in jail or hospital.

It was also through the midwives that I contacted the professionals I interviewed for the study. During the fieldwork I observed several meetings between the women and their social workers, hospital midwives and doctors, drugs workers, probation officers, health visitors, and other professionals working with the women. Though I contacted several workers to request formal interviews, I was successful in completing interviews with only two social workers, three drugs workers and two of the three midwives I shadowed. Professionals were offered no compensation for their participation apart from the coffees I bought when we met. I should note that the professionals were often no better at keeping appointments than the women. On multiple occasions I would turn up at the office of a service provider only to find that they were not in the office that day, had told no one of their appointment with me and were uncontactable by cell phone. This raised questions for me about the women’s experiences in dealing with the service providers: If the providers didn’t keep appointments with me, were they any better with their clients? What effect would that have on their relationship with clients and the
client’s ability to trust and rely on them? Did it create resentment among the clients who were penalized for failing to attend appointments when the providers did the same thing without reprisals? I am not sure I always found satisfactory answers to these questions, but they helped shape my thinking around the provider/client interactions and the nature of control within those relationships.

Occasionally the women in this study would refer to themselves as former drug users or say, “when I was a drug user.” Because the women were involved with the MSMS, they each had been encouraged and supported to reduce or control their drug use. But all of the women continued to struggle with their substance use to some degree. Thus, their use of the past tense was not necessarily an indicator that they were currently drug-free. Instead, it was a measure of their significant reductions in use or an expression of their intention to stop using. Even those women who were enrolled in a methadone maintenance program occasionally used street drugs “on top” of their medication. Nevertheless, for the purposes of this research, they are all considered to be “drug users” in part because that is how they are treated by service providers, which places their parenting within a specific context, and also because, more often than not, that is how they described themselves. Goffman, in his essay on stigma, notes that for particular types of stigma (being a drug user, for example) treatment does not return a person to “fully normal status” but transforms them “from someone with a particular blemish to someone with a record of having corrected a particular blemish” (Goffman 1963:20). Furthermore, some of the women, though stable, were faced with opportunities or temptations to relapse which, on a continuum of use, placed them closer to being a user than it did to being a non-user, giving them a particular insight into their situation not
readily available to someone who has never been a user and does not associate with other current or former drug users.

“You know. You’re a mum.”

It is an old joke that a woman doing research on mothering will succumb to the condition herself. I was not immune from this phenomenon. A year and a half into the research I became pregnant, which significantly altered my interactions with the women. Becoming a mother during the research process gave me particular insights into the bizarre and exhausting world of parenthood that could not have been achieved as deeply any other way. The change from amusing foreigner to fellow mum was instant and dramatic. Suddenly women were starting sentences with “You know. You’re a mum,” and almost as suddenly I did know.

Early in the research, I watched a woman I was talking to express milk directly from her breast into a bowl of baby rice. My judgmental and deeply un-anthropological response to this display was an internal “ick.” Fast-forward two years to my own kitchen, where my own hungry baby is waiting, and suddenly the logic of that woman’s actions became clear. Expressing milk can involve a breast pump, which needs to be cleaned and sterilized and assembled and operated, whereas her direct breast-to-bowl method required a quick flick of the wrist and no washing-up. A happily fed baby in less time than it takes to find a clean bottle. Genius.

In another instance my status as a fellow mom led to an ethical complication. One of the women told me, by way of a helpful parenting tip, that her baby was sleeping through the night due to a nightly dose of two separate baby medicines. This revelation
left me concerned for the health of the child, concerned that the woman could lose her baby to social services if I told anyone, and selfishly, concerned about maintaining my research relationship with her if she discovered that I’d “told on her.” There was a well-traded secret, among the mothers in my social circle and outside of it, that certain “baby” medications were excellent for knocking the baby out when needed. When I was preparing for a trans-Atlantic flight with my child, countless mommy friends advised me to give my baby a little Benadryl to put her to sleep for the flight. When it came time for her immunizations, my pediatrician told me to give my daughter Calpol (like baby Tylenol) in the evening after her shots so she'd get a full night's sleep. Not only did it work but also, having had my first full night's sleep in months, I could absolutely see the appeal of a guaranteed night’s rest.

In the end I decided to tell the midwives about the mother’s routine medicating and explain to them my concerns about my access, the health of the baby and social services. We decided that the best way to handle it would be to ask the health visitor to go see the mother for a “general” chat and work some advice about the medicines into the conversation. We were very conscious of not making the mother feel that she'd been "reported on", or that she was being a bad mother, but we also wanted to ensure the health of the baby.

Becoming pregnant also gave me the opportunity to experience NHS maternity care firsthand. Although private health insurance is available in the UK, the general consensus among my network of peers was that, for a “normal” pregnancy, I could do just as well on the NHS. Most private doctors also treat NHS patients. The most

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39 I may have been particularly sensitive to the health implications because in 2007, there was a highly publicized recall of several children’s over-the-counter cough medications because of the risk of deadly accidental overdose in babies.
sophisticated equipment is available in NHS hospitals, so if anything did “go wrong,” I would be back within the NHS anyway. And because maternity care is, by and large, delivered by midwives, I could get the best, most experienced care through the NHS at no cost. However, I was still able to exercise options not open to the women in my study. I opted for a home birth through the hospital’s home birth team, which meant that my pre- and post-natal care was delivered in my home instead of in the crowded and frankly depressing maternity clinic at the hospital. Drug-using women are not offered home-birth as an option. When my unduly stubborn daughter refused to be born at home, I chose to recover from my last minute Caesarean section in a private room, rather than on the general recovery ward, which is actually just a long hallway holding two rows of beds separated only by curtains. The only thing separating me from the woman whose recovery bed was being guarded by two wardens from Her Majesty’s Prison at Holloway was the £100 I chose to spend on my privacy.

My own pregnancy also brought home the difference between nine months as an abstract concept and nine months as a lived experience. Women’s failure to refrain from drug use for “only nine months” was often used by casual observers and the tabloid media alike as de facto evidence of the women’s unfitness to parent. Yet major lifestyle changes are notoriously hard to sustain, even in heart attack patients for whom failure can mean stroke or death.\textsuperscript{40} For my part, remembering to behave like a pregnant woman every day was a force of will more than it was any maternal instinct. Observing how my peers and I (grudgingly and not altogether successfully) tried to remain vigilant against

alcohol, caffeine, cured meats and countless other no-no’s, shed valuable light on the immeasurably more complex struggles of the women in the study as they tried to avoid drug use.

The arrival of my daughter also led me to ask different questions than I otherwise might have. Texting with a mommy friend at two in the morning about our shared exhaustion and hatred of breastfeeding made me wonder where these women were getting the emotional and practical support that kept my friend and me from tossing ourselves or our children out of the nearest window. Finding myself trawling the web for medical advice each time my daughter sniffled brought into focus the digital divide that still exists between women without even occasional Internet access and my own smartphone-toting peers.

My daughter also served to change the power dynamic between the women and me. Instead of the ivory tower academic researcher brimming with esoteric knowledge and authority, I became a novice in the presence of experienced veterans. The women enjoyed giving me advice on pregnancy and child rearing, and often suggested remedies for ailments like teething and colic that proved invaluable. When I brought my daughter with me to interviews, our children played together on the floor while we swapped war stories about sleepless nights and annoying health visitors. What I came to realize was that I had seen drug-using mothers as deserving of my sympathy and protection, but not necessarily my respect. My daughter taught me to value these women as mothers, not just as subjects.

The ethnographic research design was based in grounded theory methodology, which allows for the inductive emergence of theoretical concepts throughout the research
rather than the deductive proving or disproving of a particular theory. Interview and field note data were partially analyzed concurrently with the data gathering, using the constant comparison method (Glaser and Strauss 1967). I analyzed all data myself. The Atlas.ti software program was used for the management of all textual, field note and interview data. Throughout the study period, interview and field note data were reviewed and coded to guide the development of theoretical categories and the development of subsequent series of interview questions. All of the formal interviews were digitally recorded and kept in password-protected files on my secure laptop computer. I transcribed most of the interviews, though a professional transcriber was used for roughly a third of the interviews. In keeping with the transcriber’s other work for similar research projects, she signed a confidentiality agreement before embarking on the work, and all files were transmitted securely. Field notes were taken by hand and when the notebooks were not in use, they were kept in a locked filing cabinet in the London office of The Institute for Criminal Policy Research. Ethical approval for the research was granted both by the Institutional Review Board of Columbia University (IRB protocol number IRB-AAAB5976) and by the Research Ethics Committee of the Central Manchester University Hospitals NHS Foundation Trust (05/Q1410/96).

The results of my research are presented here in three parts. The first chapter addresses women’s experiences of becoming drug users, the second their experiences of becoming pregnant, and the third their experiences of motherhood. Each of these chapters sheds light on how and why women use drugs, and under what circumstances they attempt to mother their children. While the research was heavily reliant on the cooperation of the Manchester Specialist Midwifery Service, it is not explicitly an
evaluation of that service. Nonetheless, the importance of the service to the lives of these women is in evidence across each of the chapters. The women were eloquent and insightful about their circumstances and I have quoted extensively from them throughout. The final chapter draws together women’s experiences to answer the question of how drug-using women negotiate their maternity within an outwardly supportive policy and service context. The aim is to contribute to a growing body of work that seeks to inform social policies by exploring their effects qualitatively and “on the ground.” Ultimately, though, I hope this work provides this otherwise marginalized group of women a space to make their voices heard in the service of influencing their own futures.
The Drug Problem

“Every day was the same after that really. You know? Grafting, taking drugs, the same thing. Every day was just the same after that. I can’t remember how I got out of that situation… I don’t know. [I don’t] remember where I went from there. I moved around so much, you know, from place to place, and I kind of lost track of where I went after that.”

–Rachel (26 year old mother of 5)

It is possible to forget that drug users were not always thus. They had different futures ahead of them than the ones they are now living. Over time, their environments (both physical and socioeconomic), their own choices, and at times their friends and families, conspired to produce the conditions in which the women now find themselves. The “problem” with drugs for the women in this study is neither purely chemical nor purely criminal. The problem is that drugs are at once a symptom and a cause of larger, more systematic, issues in their lives. Though removing the drugs may make tackling some of these problems easier, in and of itself, drug treatment will not solve them.

The professionals who work with drug users understand this. They have seen, firsthand, the myriad problems with housing, finances, criminality, relationships and mental health that drug use can both cause and exacerbate. But the public, whose prejudices and panics are influential in shaping policy, has a more limited understanding of drug use, its causes and its consequences. There is a persistent, and at times politically useful, image of “The Drug User” as a member of a separate and distinct class of hedonistic individuals who are somehow inherently different than “normal” people, with different morality, different cultures, and different values than the rest of us. Yet, as we
shall see in the coming chapters, the drug use of mothers in this study is remarkable in its ordinariness.

The case below, of Cathy, is illustrative of many of these factors and mirrors the experiences of several women in this study. Cathy is a 28-year-old mother of a 4-year-old and a newborn. Cathy and her half-sister lived with their mother after Cathy’s father left when she was five and her half-sister eight. She grew up in a highly deprived area where drugs and criminality were common. Though she had only a year left of her schooling, Cathy dropped out at age 15 to go and live with her 32-year-old boyfriend, who then introduced her to heroin and crack. When he became violent towards her, Cathy was too ashamed to go back home to her mother. It was only when her boyfriend went to prison for abusing his ex-wife that Cathy was able to get away from him. Her experience challenges the notion that drug use is the sole root of her problems, rather than one component (albeit a large one) within a problematic matrix.

**Cathy**

I started using drugs when I was fifteen. I was doing really well at school, exams, everything…but looking really good. And, I met a 32-year-old through my next-door neighbor, who had a brother. He just got out of prison…he served about five years for some robbery that he’d done. When you’re fifteen, no one can tell you anything. You think you know everything, you know. So, I ended up…[I] started seeing him, moved in with him and started on the drugs, yeah. He introduced me to heroin and crack. I mean, why I started drugs at fifteen? I can’t honestly say what really brought me into that, you know. That’s usually when there’s something missing in childhood. I had a fantastic childhood!

Yeah. And, about three months after we’d been together…we’d been living in a big house but it was flats, a building of flats, and the person who lived downstairs was the caretaker/manager of the place and it was him who used to sell heroin…and there was always people coming and going,
scoring and taking stuff down there. And, he also sold weed and we’d go down there and smoke a weed with this guy called John…and we’d go down there and sit with him and smoke a weed…and there were a few people there taking heroin. I didn’t have a clue what it was at the time. I’d see a piece of foil with a tube made out of foil and someone just chasing this smoke and they said, “Do you want some?” They said it to Mark first… “Do you want some?” He’d already been introduced to it years and years before that, before he went to prison, but I didn’t know this at the time. You know, I was thinking, a straight and clean guy, he doesn’t know what this is…and he acted like he didn’t really know what it was. And, he was going, “Yeah, yeah, go on…have some!” And he passed the tube to me and I was going “Yeah, yeah.”

I just remember being sick, violently sick…it was this horrible taste but the buzz it gave me. it was out of this world! Then the same kind of thing with the stone (crack)...I’ll never forget this girl was laying down near the table and [had] a big pot with foil on it and her mouth to it and she was lighting it. I thought “What has she got in that?”…In the same room in John’s flat and the same sort of thing, she’s offering it to me. She said, “You want some?” and I said, “I don’t know, do I?” I’d gone “Yeah” and I had it…the same sort of thing.

There are several elements of Cathy’s story that are typical of those told by the other women in the study. The reference to a “fantastic” childhood; the physical proximity to people who were drug users and had spent time in prison; the age at which drug use began, and the curiosity of the women to try what the people around them were using, all emerged in the narratives of several women.

“Brilliant” Childhoods

Like Cathy, other women in the study often told me that they had had ”great” or “brilliant” childhoods, usually adding (without prompting) that it was not their
upbringing that led them into drug use. Instead, they described fond memories of their families and the times they had together. Emma, a 41-year-old mother who has retained custody of all of her six children (ages 21, 19, 7, 5, 3, <1), considered herself to be the “black sheep” in an otherwise excellent family. Gina, a 31-year-old mother of four children (aged 10, 9, 4, <1), was the only woman in the study to have had success with her early career goal of being a professional dancer. Gina’s three older children live with Gina’s mother, with whom Gina is in close contact.

**Emma**

I had, like I said, a brilliant upbringing, my parents couldn’t have done any better for me, you know, there’s nothing at all I can say, oh, that might have triggered it, nothing, so that’s why I say, it can happen to the best of us, because I didn’t have like--all right, we weren’t rich but we weren’t poor, and I didn’t like, I had most things I wanted without being a brat sort of thing. But, no, I could never knock, you know, like some people say, oh I was this, I was that, and my mum did this, but no, nothing at all I could ever fault them for, which I’m lucky.

**Gina**

It was only a three-bedroom house, and we always had animals, so it was very cramped, there was always a lot going on, noisy, you know, noisy, we had clothes everywhere, you know, my dad really was the boss of the house, and my dad didn’t lift a finger, he had five girls, and his wife, you know, my dad was totally doted on, you know. It was noisy, messy, a lot of fun, a lot of fights, it was brilliant growing up, I didn’t have a horrible childhood, I had a really nice childhood…Just a working class family from Wythenshawe. My mum was well known for having five girls, you know, we all went to dance classes, and my mum became a bit of a pushy mother, you know, because I had a bit of a flair for dancing, which I ended up following through. I went to stage school, and you know, I worked in all the theatres practically.
These two women saw their early lives as ordinary, fun and normal. As Emma said, although some people blame their drug use on their childhoods, she has nothing to fault her parents for. Gina says her childhood was “Brilliant” and describes a rollicking messy household of 5 girls whose mother pushed them to take the dance lessons that led to Gina’s career. Nevertheless, not all the memories they shared were unambiguously good. Women described aspects of their childhood that they found problematic, without engaging in a wholesale rejection or condemnation of their upbringing. Debbie, 28 years old, has three children (ages 7, 5, <1) the two eldest of whom are in her mother’s custody. However, unlike Gina or Emma, Debbie has had almost no contact with her children or her mother for two years. Debbie initially describes her childhood as “brilliant,” then goes on to recount how her mother’s alcoholism impacted her family. Because she never knew what state her mother would be in, coming home from school was a constant source of tension, as was the stress of keeping her mother’s alcoholism hidden from her friends and extended family.

Debbie

I don’t know, it was all quite strange, because I’d say we couldn’t really have friends and things round, because we didn’t know how mum would be. My older sister used to go out and off with friends, so I don’t know, I was just bringing my brother and sister up, but I can remember like Friday nights we’d have treats, like we’d get a bottle of Coke and a packet of crisps, and watch a film with mum and dad, do things like that. And we used to go out for days out to like Llandudno (a seaside town in Wales, UK) or down to seaside places, so I’d say in that respect it was brilliant because we always, you know, had treats, and it was all like family time. But on the other side it was, you know, this big secret we had to hide from everyone, you know, try and pretend we were normal when we weren’t, you know, it was very strange, because you go from [one] extreme to the other, I suppose.
Though Debbie describes the kind of family activities that form the basis of any child’s fond memories: movie night with mum and dad, trips to the seaside; the undercurrent running through her memories is the need to “try and pretend [they] were normal when [they] weren’t.”

The women would routinely recount events which one would have expected them to use to justify or excuse their drug use, but which they had reconciled with their overall experience. Gina, who in the quotation above talks about her young life as being “brilliant growing up,” later recounts the sexual abuse she endured at the hands of her grandfather with the knowledge of her family.

Gina

Yes, my mum’s stepdad, yes, big Irishman, yes, and it wasn’t, it was a known thing, because I remember my dad always saying when we used to go and visit my Nana, stay away from your granddad, you know, you were told stay away from your granddad. And he, you know, he used to do it as games, you know, chases, and everything, it was all inappropriate and what have you, but we were told to stay away from it, and with the kind of family we were, it just wasn’t, his wife would have known what was going on, everyone knew, but you know, it just wasn’t said.

Like Debbie’s family hiding their mother’s alcoholism, Gina’s family is engaged in a self-deception about their Grandfather’s abuses. Telling the children to “stay away from Granddad” while not actually keeping the children away from him allows the family to pretend that everything is normal. However, it also essentially places the culpability for the abuse on Gina’s shoulders. If she failed to stay away, after being told to, then it becomes her fault that he got at her. As we will see in the coming chapters, women viewed many of the events that shaped their lives as the result of choices they made while
not seeing how those choices were constrained by much larger forces. Though Gina does not feel directly responsible for her Grandfather’s abuse we can see the antecedents of self-blame in the impossible situation in which her family put her.

Like Gina and Debbie, other women in the study did not seek to make a connection between their drug use and their pasts. Women took ownership of their life choices, while minimizing the roles their families may have played in either preventing or precipitating those choices. Generally quite isolated from non-drug-using support networks, these women relied heavily on their families. It is possible that they may not have been able to risk placing blame on those they needed to turn to in times of vulnerability. Perhaps then, their descriptions of “Brilliant Childhoods” are less a matter of accuracy than they are of aspiration. There may be a tendency to idealize the past when life in the present is so hard. In a 2008 study of 38 Scottish children of drug using parents Backett-Milburn, et al. posit that this type of idealization is a form of resilience, i.e. the potential for survival and growth in the face of adversity (2008:463). The authors note that the young people in their study detailed family experiences that were “damaged and damaging”, but found that “maintaining some idealized sense of family, while experiencing its lack on a daily basis, seemed to lead some respondents to offer revised accounts” of their childhoods, sustaining a belief that their families “cared about them, even though [they were] not able to care for them” (Backett-Milburn, et al. 2008:475 original emphasis).

However, there were some unequivocal horror stories from women who clearly saw their childhoods as awful and knew that they should not have been that way. They too, however, did not blame their childhoods for their drug use. Laura is a 31-year-old
mother of two children (ages 9 and <1). At eleven years old, Laura tried to commit
suicide after being sexually abused by several of her mother’s boyfriends. When she was
released from the psychiatric hospital, her father refused to take her in, so Laura went
into foster care. But even she says that her parents were “perfect,” until they weren’t.

Laura

My mum and dad were the best mum and dad you could ask for until I was seven, and she never
drank or smoked or nothing. All of a sudden she just started drinking and going out and she started
getting in with these women and started prostituting and things like that. And that's when it all
changed. And my dad gave her chance after chance and in the end he left. It was when I was 7½.
But my mum was a perfect mum until then.

Laura is still in contact with her mother and has had to turn to her for childcare
when Laura was unable to care for her oldest son. By talking about her mother as
“perfect” until she “all of a sudden” started drinking, Laura can separate out her now
sober mother from her alcoholic mother. A framing which is not only useful for
understanding women’s ongoing relationships with difficult parents, but also for
women’s own sense of self as drug users and as mothers. Ultimately though, Laura’s
need of her mother’s support may be influencing her need to absolve her childhood
traumas from playing any role her drug use.

Zoe is a 34-year-old mother of four (ages 14, 11 1.5, <1) who is the only woman
in the study not to present a burnished family history. She has always had a difficult
relationship with her family whom she says blame her for the death of her younger
brother, who was hit by a car when she and he were walking down the street. As a child
she was abused, both physically and sexually, by her late stepfather though no one in the
family would believe her until the stepfather left their family and abused a child in his next family. Although they live down the road from her, Zoe has only sporadic contact with her mother and older sister. Their relationships are unstable with many encounters ending in prolonged (though temporary) estrangements.

Zoe

[My childhood was] not very nice, actually, because I got blamed for everything, so, like I said, I was the black sheep, so I left home when I was fifteen…[My stepdad started abusing me] when I was about, I think I was about two, or something, three, but ever since then I can remember him hitting me…because he was [sexually] abusing me, so everything was my fault…but [my family] didn’t believe me…He’s six foot under now, thank God. That’s where he deserves to be.

Even Zoe, though, does not seek to excuse her drug use with her story of trauma. She tells it as a matter of history, not causality. As has been explored before, the relationship between childhood trauma and future prevalence of drug abuse is complex. An excellent meta-analysis by Simpson et al. (2002) of over 125 (predominantly US) studies published between 1970 and 2000 examining the link between childhood sexual assault (CSA) and drug use found that there is significant correlation between them for women, but not for men. Women who use drugs report higher rates of sexual assault than do those in the general (US) population (60% vs. 27%), and women seeking help for mental health issues related to CSA are almost three times as likely to report drug use than are women in the general population (40% vs. 14%). It has also been shown that women who experience trauma are more likely than men to use drugs to self-medicate for symptoms of depression, PTSD, and anxiety associated with experiencing trauma (Fullilove, et al. 1993; Fullilove, et al. 1992; Paone, et al. 1992; Sales and Murphy 2000;
treatment, women are more likely to relapse as a result of trauma, whereas men relapse
when presented with drug cues (e.g., watching people using or preparing drugs) (Hyman,
et al. 2008). Although not all women who have experienced CSA will inevitably use
drugs (population estimates for rates of CSA for women hover around 27%, whereas drug
use is around 14%), it seems that for those women who experience mental health issues
as a result of CSA, self-medication with illicit drugs is a likely outcome. In other words,
not all women may experience CSA as traumatic, but those who do may seek to self-
medicate with whatever means are most readily available. Although women in this study
did not report CSA or physical abuse as the conscious cause of their drug use (five were
victims of CSA, and three were victims of childhood domestic violence), it is possible
that drugs, once experienced, provided welcome relief and escape from emotions brought
on by trauma and hardship.

Still, we cannot look to CSA as the entire root cause of women’s drug use. As
noted in the above studies, many more women have experienced childhood sexual abuse
than are drug users. Almost half of the women in this study (six) did not report a history
of CSA or childhood domestic violence, yet they clearly used drugs. There are other
factors, like the overwhelming prevalence of drugs within their neighborhoods, and social
networks that may have had a larger influence on their initiation into drug use. After all,
you cannot self-medicate with illicit drugs if you do not know where to obtain them.
Social Networks to Drug Networks

In Cathy’s story at the beginning of this chapter, she talks about the caretaker of their block of flats who also happened to be dealing drugs. Being in regular and close proximity to drugs from a young age was a feature of the lives of many of the women. The social categories of family, dealers, neighbors, drug users and friends frequently overlapped. Women’s introduction to heroin and crack use was not so much a downward spiral into chaotic drug use as a bleary-eyed blunder into the lamppost of addiction.

While drug use can certainly tighten one’s social circle so that it begins to seem as though the whole world is using, for these women, the circle around them was already well permeated with drugs. Women didn’t need to stray far from home to come across opportunities for “hard” drug use. (They would have needed to stray far to avoid them.) When women talk about how they were first introduced to drugs, what is startling is not how extraordinary the circumstances were, but how ordinary. They were introduced to heroin or crack by friends, boyfriends, family members, and in two cases, by women they babysat for. Next-door neighbors were ex-users and ex-prisoners. Co-workers at an insurance firm were dealing heroin on the side. Gina’s introduction to heroin was through a boy from “a lovely family” next door.

Gina

I was fifteen and a bit. I remember because his mum and dad were great, you know, they’re a lovely family. But I remember…when I used to go to his house, because I used to have to go around the back, climb over, you know, I couldn’t just go straight in his gate, you know. If my mum knew, she’d go crazy. And all his friends would all be there. And I used to wonder why all these friends are always tired, you know, because they’d all be asleep, you know, or gouched (high) or whatever. And then little by little he said, “Would you try this drug, that drug?” And me, because I thought I could do anything, I thought I was invincible, you know, I really did when I
was younger. Nothing was, there wasn’t anything I couldn’t do. If a fella could do it, I could do it better. “Would you try heroin?” “Of course I’ll try heroin.” You know, and then the next night he pulls a piece of foil out the drawer. And then, you know, what do I do? I can’t back down, can I? So it started off as a little smoke and, you know, I’m sick and that, then, you know, a few days after, a little more. And before you know it, you’re in trouble.

Gina had to sneak over the fence to get to the boy’s house where “they’d all be asleep” high on heroin, because her mother would “go crazy” if she knew (even though they were a “lovely family”). When the family with five dancing daughters lives next door to a house full of teenagers getting high on heroin a picture emerges of a community where drugs are plentiful, accessible and even somewhat acceptable. Mary, a 27–year-old mother of a newborn, says, heroin use wasn’t a “big issue.” Mary comes from a large, close-knit family and lives with her mother and sister in her mother’s house. Although Mary was never abused as a child, she has witnessed her mother being beaten repeatedly by her long-term boyfriend over the years. Nevertheless, like the other women in the study, Mary does not blame her use of drugs on the negative experiences at home, but sees it as the effect of being “around all the people” who were using drugs.

Mary

No, I was around all the people. They all did smoke weed as well. I can’t seem to think how it just come about, how I got involved. And me and my friends, well, not friends, a friend, we used to babysit for someone called Sharon, and she used to smoke weed, Sharon, it was through a babysitting job when I started taking heroin, and the woman who I used to babysit for called Debbie. Yes, once she’d come back, and then either she asked me did I want some, or I asked her, and she gave me some, it didn’t, just like, come off a big issue and I was, because I was there every day as well, because I had the kids. So she used to pass me the tube, and just, and did it for
me, because I couldn’t, I didn’t know how to do it myself. So after a bit it just became a thing like, do you want a cigarette, you know, it wasn’t like a big issue.

Mary doesn’t remember if she was offered the heroin or if she asked for it, which indicates that seeing someone using heroin was not an exceptional or startling experience for her. On the whole, women were introduced to drugs by people they knew and trusted. Prior research has indicated that women are often introduced to drugs by intimate male partners (Gossop, et al. 2002; Martin 2010; Rhodes and Cusick 2000; Rosenbaum 1981), but what is interesting here is that it was not just boyfriends, but also female friends and family members, who were critical in the women’s initiation. Women in this study belie the image of vulnerable women being pressured into use by domineering men. Rather, for these women, drug use did not exist far outside the realm of “normal” behavior. When your sister and your neighbor and your co-worker are all using heroin, it loses some of its taboo. Instead of involving a terrifying descent into a criminal underworld, hard drug use was on a par with illicit underage drinking, a bit naughty but not utterly destructive.

There is a marked lack of resentment in the stories the women tell of those that introduced them to drug use. Only one woman, Kristen, was angry at her cousin for “getting her hooked.” The other women, though disappointed in themselves for being drug addicts, are not angry at those who helped them get there. There is, instead, a sense of resignation that “these things just happen” when you are “only young” or “fall in with a bad crowd.” There is the sense that, like stumbling into a lamppost, it could happen to anyone.

Still, despite the prevalence of drugs in their social circles, several women remarked on how naïve they were when first introduced to heroin. Each told stories of
wanting to try what they saw their friends doing without knowing what it was. It was only after they found themselves feeling ill without the drug that the friend or cousin or boyfriend told them what they had been using. Kristen, a 35-year-old mother of three children (ages 13, 9, <1), moved from Glasgow, Scotland, to Manchester with her mother and two of her five siblings when she was 12 years old to take care of her widowed maternal grandmother. Kristen says that her parents were “strict in proper ways,” never letting her stay out late and grounding her for a week the one time she skipped school. Unlike Cathy, Kristen completed her school at age 16 and worked first in a “machine factory making jumpers” (sweaters) then, when that work grew too boring, at an elderly care home. Kristen left the job in the care home when a resident she had grown close to died suddenly. When Kristen was 17, around the same time she was working in the care home, she was introduced to cannabis, though she says she never liked it and “didn’t need to bother with it.” It was through a cousin that Kristen first encountered heroin.

**Kristen**

I was with me cousin, at my friend’s house, and she was smoking. And I kept askin’ her what it was and she kept sayin’, “It’s nothing really. It’s nothing really.” And she kept sayin’, “Do you want a bit?” And at first I said no. Then one day I just tried it and started having it, not every day but every now and again. Then I started taking it regular. And before I knew it, I was addicted to it. Didn’t know nothing about it. Then I woke up poorly one day and she told me about it. Oh, it was horrible.

Like Mary, Kristen witnessed heroin use for some time before she tried it but says that she didn’t know what it was that she was taking and “before she knew it” she was addicted. There are several possible interpretations of the stories of naiveté women tell about drugs. One is that women really *did* know what they were getting into but do not
want to admit their complicity in their downfall. After all, in neighborhoods where the “boy next door” is an ex-con and your cousins are using heroin, it feels disingenuous to claim ignorance of such a strong undercurrent of drug use. Further, there are such similarities in the stories of initiation – the novice discovering too late that the safe space of friends and relations is actually a den of iniquity – that it almost seems a fable passed from one user to the next. Yet women were far more likely to overstate their own liability for their actions than to understate it. Recall that their childhoods were “brilliant” and they had “no one to blame but [themselves]” for getting into drug use.

Instead, I suspect that women truly were ignorant of the drugs around them, not because they were childish innocents, but because they had not been adequately warned of their dangers. When mothers in this study were asked at what age they would tell their own children about drugs, many of them, anxious to protect their children from harm, said around age 15. Yet they themselves tried drugs between the ages of 13 and 17. Cathy talks about how her mother was “devastated” when she went off to live with her 32-year-old boyfriend at age 15, even going so far as to physically drag her back from the boyfriend’s house several times. It was not that her mother didn’t care, or did not try to help, but more that Cathy may not have had the resources to make different decisions in the first place.

Although good in moments of crisis, the social networks of the women in this study were not always healthy or effective in giving the kind of everyday help and support the women needed. Four of the women described childhoods like that of Debbie’s, where they felt compelled to assume the care of their siblings because their mothers “went off the rails” when they were younger. In this light, the idea that “no one
can tell you anything” takes on a new character if instead of not listening to advice, women were not actually getting any at all. One could even argue that for Cathy, finding a stable older boyfriend with whom she could set up house was a reasonable life choice to make given her circumstances. Like most of the women in this study, Cathy did not have any specific career aspirations when she was younger, or any vision of what she would “do” with her life. Though she and the other women had held jobs at various points, they did not organize their identities around their work. Instead, they planned to have a nice house, get married and have kids. For Cathy, moving in with her boyfriend was a move into adulthood.

At the same time, well-meaning family members may simply not know the best way to help a struggling child. Juliet, a drugs worker, tells the story of a client’s mother who desperately wanted her son to get into treatment, but also gave him money because she didn’t want to see him suffer or commit a crime for his habit.

**Juliet, Drugs Worker**

I had this conversation where I, unfortunately she’s been in tears on the phone, it wasn’t deliberate, but I said to her, “You ring me and you want me to get him into treatment.” I said, “The trouble is these things don’t just happen. I really need you to consider, like you said last time, not giving him the money for drugs. If you’re concerned you don’t want him on the streets, then pay his bills for him. You know, give him food if that’s what you want to do. But don’t give him money for drugs.” And she said, “You don’t know what it’s like.” And I’m sure I don’t. But it’s like, families help and don’t help in lots of different ways, and I think most of the time they’re a bit of a hindrance in some ways.
The mother in the above story is clearly trying to be supportive of her son, but chooses a method at odds with her long-term goal of getting him off drugs. As Juliet says, family can be a “bit of a hindrance” at times.

**Gateway Drugs**

Women in the study had been using heroin or crack for an average of fourteen years by the time I met them. When I asked women to describe their first experiences with drugs, many began by discussing their introduction to heroin. It was only by unpicking accounts of “smoking” as teenagers that it became clear they occasionally meant cigarettes, but more often meant smoking cannabis. None of the twelve women who used heroin were also currently using cannabis because they said the two drugs didn’t mix well. Past cannabis use was an afterthought that didn’t really “count” as drug use. It may be that women saw cannabis this way because that is the way cannabis use is treated by service providers and the law,41 or because they had been using drugs for so long that “milder” drugs did not register in the same way.

The role of cannabis as a “gateway drug” has been hotly debated since the theory was first posited in 1975 (Kandel 1975). The idea is that drug use progresses uniformly from tobacco to alcohol and then to cannabis, which serves as the “gateway” to harder illicit drug use. At least one of the theories regarding this progression is that cannabis somehow alters the brain, creating a subsequent need for opiates (Ellgren, et al. 2007). The validity of the gateway hypothesis is important because it forms the basis of much of

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41 Recall that cannabis was decriminalized from a Class B drug to a Class C in 2004 to allow the police to focus on more “serious” crimes and drugs that posed a larger public health and social threat. [http://www.homeoffice.gov.uk/drugs/drug-law](http://www.homeoffice.gov.uk/drugs/drug-law)
the social policy surrounding drug use, though different policy makers interpret the implications differently. In the US, the thinking is that if you restrict access to the gateway drug you necessarily lower the risk of progressing to harder illicit drugs; therefore, cannabis use is prohibited. In the Netherlands, in order to break the link between cannabis and harder illicit drugs, cannabis is legalized in small amounts to try to make it more like alcohol and tobacco and take it out of the black market where harder drugs are sold (Hall and Lynskey 2005). There are literally hundreds of studies that examine the gateway hypothesis from genetic, pharmacological, economic and/or sociocultural standpoints (see Hall and Lynskey 2005 for a good review of the competing sides and explanations). Recently, some very persuasive studies have challenged the hypothesis on the basis of cross-national data (Degenhardt, et al. 2010) and the positing of a common-cause hypothesis (i.e., that some people are predisposed to drug use in the first place, which makes them more likely to try any drugs) (Degenhardt, et al. 2009; Morral, et al. 2002a; Morral, et al. 2002b). Degenhardt et al.’s cross-national data (2010) from seventeen countries highlights the fact that most research on the gateway has been done in countries where tobacco, alcohol and cannabis use are common. They show that in countries where cannabis is uncommon, like Japan, initiation into “harder” drugs occurs first. They also show that the age of onset of any drug use is a better predictor of developing dependence on drugs than the specific drug first used. In an earlier study Degenhardt et al. (2009) also show that, regardless of the first drug used, psychiatric comorbidity (e.g., PTSD) is a strong risk factor for developing drug dependence. This would seem to support the research highlighted above that women self-medicate with illicit drugs for trauma.
Though the sample in this study is far too small to be conclusive, it might be tempting to view women’s early cannabis use as further evidence of a gateway effect. However, their early introduction to drugs, the way they discuss heroin and crack use as “no big deal,” and their histories of CSA and domestic violence, when looked at in aggregate, seem more likely to create the conditions for hard drug use, as Degenhardt describes, than would the chemical or social action of cannabis alone.

**Heroin Users Versus “Smackheads”**

Women in the study were careful to distinguish between their own use and that of “smackheads” or “junkies”: chaotic users who had “no proper feelings” about how to maintain control over their use. Control could take the form of using only on weekends, or only once a week, or only in certain locations in the house – specifically, away from the children – anything that placed limits on use. Unlimited use or binging was irresponsible and ultimately unaffordable. It was also seen as hedonistic; a pursuit of pleasure for pleasure’s sake that could not be otherwise justified or rationalized. As mentioned above, within their neighborhoods and social circles, drug use did not exist far outside the realm of “normal behavior,” but being a smackhead was where they drew the line, and from there the stigma. Emma the 41 year old mother of 6 children draws the distinction between smackheads and heroin addicts as between people who commit crimes to feed an uncontrolled habit and people who have a problem that they are “trying to address.”

**Emma**

It’s like I’ve always said, there’s smackheads, and there’s heroin addicts, or people that have got a drug problem. Two different things. A smackhead will go and rob their nana’s video. The people
with a drug problem have genuinely got a problem and they’re trying to address it sort of thing. Like me, I’m on my meth(adone)… I’m all right. I look after my kids. They’re in school, they’re clean, they’re well fed, they’re well loved. If [methadone] keeps me going then so what? I don’t have to pay for it. I don’t have to go grafting for it. I don’t end up in jail for it. So that suits me, and that’s how, you know, it’s my decision at the end of the day.

Emma argues that her kids are clean, well fed and in school so it is nobody’s business if she uses methadone as long as she’s not “grafting” (stealing) to fund her use. For Emma and the other women in the study, being a smackhead was associated with being unclean: having a dirty house, smelling bad, or looking “like a junkie.” Being “clean” has long been a term of particular significance within the world of drug abuse, from the perspective of both the user and the treatment community. For this population, being “clean” refers to physical cleanliness, the state of being drug-free and that of being disease-free. One can also be “clean cut,” which indicates social respectability and propriety. These links between moral or social goodness and cleanliness go back to at least as far as Roman and Hebrew traditions, but they were solidified in modern times during the 19th century, when scholars like Sir Francis Bacon asserted that “the cleanliness of body was ever esteemed to proceed from a due reverence to God” (Bacon 1886, quoted in Bushman and Bushman 1988:1217). The British and American upper classes began to embrace routine bodily washing as a mark of rank and an outward sign of moral purity. In popular literature of the day, ascent up the social ladder could be achieved by descending into the bath. At the same time, the medical /scientific communities were beginning to make connections between filth and disease. Thus, good health became a sign of moral goodness and poor health of moral degeneracy (Bushman
and Bushman 1988). This was solidified in the public health and social hygiene movements of the 20th century, which further “confounded images of cleanliness, morality, health and social acceptability” (Balshem, et al. 1992:156).

For the drug using community, there is a very real link between disease and cleanliness for intravenous drug users, who may risk their lives through the use of dirty or shared needles and “works” (i.e., spoons, filters, water) which can facilitate the transmission of HIV, Hepatitis C and other blood-borne infections. However, users’ perceptions of the safety of sharing injecting equipment are influenced by their assessments of how moral a fellow user is, and therefore how likely he or she is to be infected (Lawless, et al. 1996; McIntosh and McKeagney 2000; Rhodes, et al. 2008).

For drug users, already seen as morally degenerate, physical cleanliness is a means of demonstrating that you haven’t let the drugs overcome your ability to uphold basic standards of human decency (Adams and Raisborough 2011; Balshem, et al. 1992). A physically unclean user is seen to have crossed the line from control into chaos. Such users are also seen as more likely to harbor sexually transmitted diseases, as found by Balshem et al., who discovered that “respondents speak of syphilis as being a disease of dirty people, people who have let go of the effort to stay clean” (1992:152). This population of women was no different in feeling that cleanliness was a sign that you had not let the drugs overcome you.

Beverley, a 27-year-old mother of a newborn, had been using heroin for over ten years. At the time of our first interview she was living with her boyfriend (a married man whose wife had also just had a baby) in a brand new housing development. Her boyfriend
didn’t like Beverley’s drug use, so she had to hide it from him as well as from everyone else. Being well presented was, to her, the best way of hiding her use.

**Beverley**

People just think that heroin addicts, drug addicts, especially heroin addicts…because you see the people in town and they don’t have baths, they stink. There’s no need to be like that. I’ve always [liked] to dress nice or…. don’t get me wrong, some days I can’t be bothered…[but] I was on it for two years before anybody found out.

Vicky, a 42 year old mother of a newborn has been using heroin since she was a teenager. She views “junkies” as not only physically dirty, but also unable to care for their children.

**Vicky**

And I’ve been in some junkies’ dens, and you know, some of them are rough, some of the kids have even been taken away from them for the state they’re in. You know, leaving the kids in shitty nappies and all that. And users are coming in and out the house, and it’s not nice, it’s not nice that they’re brought up like that.

From the perspective of a mother, too, there are things that you can tolerate for yourself that are unacceptable to inflict on your children. Reference to a “shitty nappy” is a judgment on a woman for tolerating filth as well as for neglecting her children’s basic needs. Many of the women described their own parenting in terms of their ability to keep their children clean and in clean clothes. There is a strong link between the cleanliness of a woman’s home and being allowed by social services to keep her children. Being a “smackhead,” therefore, is as much about fitness to parent, as it is about the ability to function as a “normal” person.
John, Social Worker

You also look at the environmental factors … you’re looking at the accommodation in general. You’re looking at whether it’s clean. Whether it’s, you know, it’s got feces all over the floor, et cetera. If it’s got running water, you know, if the child can have a wash, et cetera. And if there’s a means to cook meals, there’s a cooker, et cetera. So you’re looking at all those basic factors and whether that parent can provide all those basic needs for the child.

From the women’s perspective, “smackheads” are also seen to adhere to a different code of behavior than heroin users. Apart from being dirty, a “smackhead” will steal from the vulnerable, whereas a heroin user might be forgiven for shoplifting, which is not seen as harmful to anyone. A shop is an anonymous place owned by a nameless wealthy corporation. There is no harm done in stealing from someone who can afford the loss.42

Cathy, the 28 year old mother of two, explains that people who do terrible things and then blame it on the drugs are actually materially different from good people. She says “you’ve got to have it in you” to do something as abhorrent as steal from your own Grandmother. Though she says drugs do make you do things you wouldn’t ordinarily do, like shoplifting, there is a line not to be crossed by decent people.

42 In considering the acceptability of stealing from a shop, one can see the precursor to the opportunistic looting of the London “riots” in the summer of 2011. If shoplifting is not harmful, then a little casual looting is only a minor infraction. Similarly, for this population, going to prison is a fairly regular occurrence for themselves, their acquaintances and sometimes their family members. Often I’d be told about someone’s nephew or cousin who was “such a good lad” though “he’s just in prison at the moment,” so I’d have to wait for a formal introduction. If prison is neither exceptional nor detrimental to one’s trajectory, it doesn’t offer much of a deterrent to breaking a law generally taken more as a suggestion than as gospel. There is also an element of not being the fool who didn’t get in on the good thing while it was going. The orderly queues of looters lined up with shopping bags awaiting entry to a recently breached shop speak volumes about the ordinariiness of the whole affair. If shoplifting and prison are inevitable, then why not at least get a decent TV out of it as well?
Cathy

I used drugs, Abigail, but there are certain things you just don’t do. I’m embarrassed and ashamed to say I shoplifted in my life, I sold me body in me life. I’ve done that. But there’s certain things, like me mum’s handbag or robbing people’s mail that I couldn’t do. I’d withdraw to death and beg for the money and say “Please, please, have you got a tenner? [£10]” And beg for the money [rather] than do that. I just couldn’t do it, it’s not me. When people say, “Oh, the drugs made me do it,” I think to meself, “No, I’m not having it.” Because I’ve been there, withdrawing badder than bad. But [something] stopped me. Whatever stopped me from doing that. You’ve gotta have it in you to do, you know, to rob your Gran, or you’ve not. You know? Don’t get me wrong, drugs can make you do certain things, like shoplifting, that you wouldn’t normally do. But, the sure thing is you draw the line and say, “No. That’s too far. That’s too much. Don’t do that.”

Vicky, too, makes a distinction between people who use drugs and people who steal from others in order to use. For her, it is being labeled a junkie when she feels she doesn’t deserve it that upsets her.

Vicky

I’ve been into drugs thirty odd years, and I’ve never robbed anybody for it, so there’s different categories in drug users, it’s just that it’s a label that people has given other users. So it’s not fair, not everybody’s in the same category.

And yet, while roundly condemning “smackheads” when talking about their own use, women reflected that they might have drifted into the realm of junkies and smackheads in the past, though always in terms of extremes of use, rather than the types of offenses committed.

Mary

You see them in town and they look off their head and I think, did I ever look like that?
Emma

Just, it’s like, it’s how I was then compared to how I am now. This is the most stable I’ve been for a long, long time. Like say, I didn’t have my meth script when I had like, I think, Peter and Levi. And I was going out grafting, taking them with me. I’d be on the shoplifting, and just going out rattling (withdrawing) with two kids. Trying to function for them, but then you’d, you’d feel like you’re dying yourself. Having to go out in the rain grafting, and selling your stuff, and then scoring (buying drugs). Oh God, it was unbelievable. I don’t even know how I did it. Because the thought of it now, oh, I just wouldn’t do it. But I did then, and it was, it was chaotic. Driving about in nicked cars, and all that. I mean, you just don’t think of the consequences, or, like, the impact it has on the kids, because you’re just thinking, like, “I just want to feel better.” And do you know what I mean, madness? But I just couldn’t do it now.

Women could use the specter of the smackhead as a way to contrast their own controlled and occasional use with that of the dirty, uncontrolled junkie. In so doing, they were essentially demonstrating their acceptance of the common drug-user stereotypes while at the same time placing themselves outside of them. Women justified their own, non-junkie, use in three primary ways: as a form of self–medicating; as simply a bad habit, like fingernail biting, that could be easily curtailed; and as an occasional, well deserved treat. In particular, they distinguished between the hedonistic, compulsive and uncontrolled use of the smackhead and their own minor controlled indiscretions. They used the justifications interchangeably, sometimes citing the need for a treat, and other times the need to feel normal. There was an almost knee-jerk reaction when talking about their current use to disavow any pleasure in the practice. Taking pleasure was a violation of the heroin-user label and a turned the sympathetic woman deserving of help into the
wanton pleasure-seeker deserving of censure. Even those that used as a “treat” would claim that they did not really enjoy it and it was more the routine of it that kept them going back.

Vicky’s use of “junkies’ dens” conjures images not just of a dark hovel, but an animalistic one at that, further removing the junkie from the realm of “normal” people. As Goffman says, “We believe that a person with a stigma is not quite human” (1963, p. 15). Junkies are not normal, like us. Interestingly, Vicky, a 42-year-old mother of a newborn, said she was “over the moon” when she discovered her pregnancy because she assumed she could never have children. Having a baby, she said, made her feel more “normal.”

Being “normal” had two primary meanings for women in this study: normal as in non-user, or normal as in physically able to function. Normal women or normal mothers did not use drugs and were not on methadone. Normal women had enough money to buy their children the things they wanted, and had strict routines that they consistently followed. Normal women did not have breaks in their parenting. Normal women also did not need drugs to feel normal. Polly, a 21–year-old mother of a newborn, is disturbed by her continued need for drugs and alcohol. She lives alone with her newborn in a house several miles away from her family, with only occasional visits from the father of her child.

Polly

I’d like to give it up still because I wish I could just be normal and chill in the house like everybody else, normal mothers would do without having to have, you know, drink or drugs, but I am getting there, I just keep praying about it, and hopefully I will be able to just give up one day.
In contrasting herself with “normal” mothers we can see the reflexive embrace of the idealization of motherhood that sets women up to believe that “normal” mothers enjoy being locked in their homes with only a newborn for company for days on end. As many others have pointed out, plenty of “normal” women’s “experiences of good mothering are more frustrating, isolating, exhausting, depressing and difficult than anticipated” (Banwell and Bammer 2006:506).

**Drugs as Medication**

Most frequently, women described their drug use as a form of self-medication for pains both physical and emotional. Despite being enrolled in methadone maintenance programs, women occasionally needed to “use on top” in order to feel “normal.” In many cases, “normal” meant not withdrawing, or “rattling” as it is called. Unlike some stimulant addictions, heroin addiction is more than just a strong psychological craving. With heroin, the body actually becomes physically dependent upon the drug. Withdrawing from heroin can feel like an intense bout of flu, with chills, body aches, and nausea that can be quelled only by more heroin or an opiate substitute like methadone (Klee 2002). As any mother who has woken up with the flu can testify, the prospect of caring for children while you are yourself sick can be a daunting one; to be faced with that sickness daily would be Sisyphean.

Emma and others expressed the feeling that they would like to come off the heroin completely, but that they were unable to cope with the pain of withdrawal and caring for small children at the same time.

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43 “Rattling” is an apt term, given the chills associated with withdrawal that literally leave the body shaking like a rattle.
Emma

Yes, I can just go about my business. [Methadone is] like a heroin substitute. And like I said, when you come off heroin in prison, everything does hit you. All your emotions. And you do think back too. So in a way [heroin] is a bit of, like, a block, but that’s not why I have it. I just have it because I don’t think I’m ready to even do a little rattle while I’ve got all the kids, I just couldn’t do it.

Zoe, who has two rambunctious boys under the age of two, feels she cannot cope with them and experience withdrawal at the same time. As she says, she’s not using the heroin to make caring for her children “easier” per se, she is using to make it possible to function.

Zoe

It’s not that it makes it easier. It’s just, like, if I’ve missed my methadone or something I’ll get a bag. And like, if I’m rattling (withdrawing) or something [the children are] so annoying. They don’t mean to be, but it’s like with them playing about now, it would be winding me up, you know, if I didn’t have anything. They don’t mean to be. It’s not their fault.

One could reasonably wonder why, if the women were in a methadone maintenance program, they would need street heroin at all. The answer lies, in part, in the way methadone is distributed. The primary requirement for the program is that you pick up your “script” (prescription) from your doctor or drugs worker on a regular basis. Depending on how reliable or stable the drugs worker judges you are, you may receive either a daily, weekly, fortnightly, or monthly supply of methadone. For women on a daily script, that means showing up at the chemist every day to pick up your dose of methadone. In some cases it can even mean a “supervised script,” which requires you to
take the dose of methadone in the chemist’s shop while the chemist watches. A missed appointment means a missed dose and a missed dose means pain. If a user cannot bear to suffer until she can get an appointment with her worker, and then get to the chemist to fill the prescription, she turns to the next best thing, street heroin.

The secondary goal of maintenance programs, though one that few ever seem to achieve, is to gradually reduce the dose of methadone until it is no longer needed at all. Among users willingly in treatment, there is a strong sense of pride in reducing the dose and a corresponding feeling of shame and failure in asking for an increase. In pregnancy, this can be particularly problematic because women, understandably, want to be on as little heroin or methadone as possible in order to protect their children from potential harms *in utero* and from withdrawal at birth. However, due to the nature of a growing fetus, a woman may need to increase the dose of methadone she is on as the pregnancy progresses. The midwives explained it to me as the fetus beginning to take more of the drugs from the mother’s body, though I expect this was their translation into layman’s terms of a more complex phenomenon involving increased maternal blood flow. As the fetus grows and her body changes, she feels her withdrawal symptoms more which necessitates a higher dose. Pregnant women who have been making progress in reducing their drug use often find the need to take more drugs during pregnancy both counterintuitive and depressing.

The same holds true for non-pregnant users who find themselves needing more methadone to keep from rattling. There is shame in asking for an increase, whereas heroin is cheap and plentiful. Additionally, there is a feeling among many users that the drugs workers simply “don’t get it” when it comes to getting off heroin. Women in this

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44 This is to prevent people from reselling their methadone through the street markets.
study, and users in other studies I have worked on, routinely expressed the feeling (not always justified) that some of the service providers they worked with were useless, ill-informed, and incapable of giving the users any meaningful help. In that context, it is unsurprising that users turn to self-diagnosis and self-medication when faced with problems. When the remedies offered by the professionals do not work, it is seen as further evidence of the professionals’ incompetence and a reaffirmation that the user knows best.

Another use for street heroin was as a substitute for over-the-counter medication. Heroin was the drug of choice for a range of conditions from a bad cold and lethargy to postnatal pains. Most commonly, women in the study self-medicated with heroin for emotional pain. As mentioned above, women did not feel that they began drug use as a direct result of emotional pain, but when they describe the effects of heroin and their choice to continue using, all of the women referred to the ability of heroin to ”blank” emotions and memories. Cathy uses it to dull the pain of her partner’s death. Debbie uses it to combat depression, and Zoe uses to “forget for a bit” the significant hardships she’s had through the years. As Cathy says, it puts you in a “warm bubble” where all your problems are taken away.

Cathy

[My partner died] about 4 or 5 years ago now. And, that hit me quite hard. I would say I did delve into the drugs then, after that. And then, [his mom] said, “Don’t let his death be in vain…you’ve got to come off it now!” But if anything, it made me go the other way. It made me think “I can’t deal with this…this is too much…give me some heroin and just let me forget my troubles.” You know? Like a warm bubble it just puts you in…that’s how it feels when you have it…like, none of

45 Their mistrust of drugs workers is particularly interesting as many of the workers I encountered were themselves former users. Though perhaps it is only those workers who are not so experienced who engender derision.
your problems are there. You know? Obviously they are tenfold the next day but it just takes everything away. You can deal with anything, your confidence soars. You know? And I got back into it.

Debbie
The boys went away for a few months while, you know, I got myself clean. And I came home, and I was fine. For quite a while I was all right. But then slowly but surely, you know, I got myself down, depressed again, and the only way I’d known how to sort myself out was to have a smoke.

Zoe
Well, it just makes you forget for a bit, doesn’t it, what’s ever happened to you in the past. But it doesn’t make you forget completely, so you’re just out of your head. You don’t remember anything, do you? As soon as you wake up it’s still there, no matter what. You can’t forget anything because it’s still there.

These women know that heroin is not a long-term solution, but it is the quickest, most accessible and most familiar. Having been on heroin for an average of fourteen years, the women in the study had few, if any, other coping mechanisms at their disposal when things got hard. Talking therapies, where one might learn new coping mechanisms, are expensive and therefore limited on the National Health Service, whereas drug therapies are cheap. Suzie, a 20-year-old mother of a newborn who struggled with post-natal depression, said she wanted help but was offered only antidepressants.

Suzie:
Yes, I went to the doctors and everything, it was… just, do I want to go on anti-depressant tablets? and I went, “No I don’t want to go on them. I’d rather try and sort myself out.” Because everyone I spoke to that’s been on them have been on them for years now, and I don’t want to go on anything like that.

The irony in Suzie’s refusal of antidepressants is that she and her fellow users have been on street drugs “for years now” too. The difference is the seemingly self-regulated nature of street use (“it’s just a habit”) versus the literally prescriptive nature of official drugs. Making a choice to come on or off street drugs is one perceived as wholly within the user’s control. Prescribed drugs however come with official oversight and sanctions for inappropriate use. As will be explored throughout this and the following chapters, the need to establish control over at least some aspects of their lives is a theme that recurred throughout the study.

Consider too that a doctor may write one prescription that lasts for six months, but a psychologist needs to be seen weekly, potentially for years, in order to have a lasting impact. Access to proper psychotherapy is difficult for the average citizen, and much more so for drug users, who may not know to ask for it or indeed what to do with it once they get it. Instead, they are served by a hodgepodge group of drug workers and counselors who, though well-meaning and hardworking, often have little more than a cursory training in talking therapies. In my prior work with drug counselors I found that each offered a range of therapies, from motivational interviewing to cognitive behavioral
therapy, often with little more training than a weekend workshop or two to provide competence in the vocabulary, if not the technique (Weaver, et al. 2009).\textsuperscript{46}

Whether or not trauma caused the initial foray into drug use, the lifestyle the women adopted subsequently would provide plenty of trauma to “blank” out with heroin. Street crime, arrest and prison, part of the experiences of twelve of the fourteen women interviewed for the study, would be memories anyone might want to erase. However, women did not always see drugs as solely a counter to depression. As Emma said, “When I’m happy I used to use. And when I was sad, I used to use. When I used to get elated I’d think, ‘Right, oh, I’m going to go and score.’ And then when I was dead sad I would go and score because I was sad.” Her approach is not surprising given the similar role that alcohol has in celebrating victory (Champagne!) and consoling defeat (Set ‘em up Joe!)

**Drugs as Routine and Treat**

One of the many things I discovered in becoming a mother while researching mothers was the importance of treats “just for me,” Sometimes that meant getting to shower, wash my hair and brush my teeth all in the same morning, but more often (and infinitely easier to achieve), it was a glass of wine at a play date. At almost any gathering with our children, my friends and I would begin to debate whether 2:30 in the afternoon was too early to break out the “mama juice.” The goal was not to get drunk, or to blot out painful memories, but just to feel like an adult instead of like a mother. By sharing a glass

\textsuperscript{46} Perhaps, though, it is my American belief in the power of incessant talk that makes me feel as though “proper” talking therapy would be more effective for these women than drug-based interventions. That said, in Britain there is a growing trend, embraced by some and ridiculed by others, toward American (i.e., Oprah Winfrey or Jerry Springer) style confessional and confrontational television. Jeremy Kyle and Trisha Goddard, hosts of separate daytime “talk” shows, have no trouble recruiting countless individuals to describe their incestuous pregnancies, abusive relations and various other falls from grace, for the entertainment of their fellow Brits. For amusing takes on quintessential Britishness, see Fox 2005 and Bryson 1995; for equally amusing, if somewhat painful, examples of the ridicule of the new confrontational television, watch “Shameless” (UK version) and “Little Britain.”
of wine, we were harkening back to a time before our babies and their endless bodily functions made conversation impossibly one-dimensional and relaxation simply impossible.

For drug-using mothers, “mama juice” was replaced by “a smoke”, or “my little bit.” It was a combination of habit and treat that normalized the drug use in their eyes.

**Rachel**

I think it’s because I’ve been doing it for so long now, it’s become such a habit for me. You know, such a routine thing. That’s what I’ve got to get out of. You know? That routine of using every day. It’s not because of what I’m getting out of it. It’s that routine I’ve got myself into. It’s getting myself out of it. You know? That’s the hard thing.

**Emma**

I’d say it was a treat, but it’s not even a treat anymore, like I said, it’s just routine… Yes, it takes me ten minutes to do it, and then it’s gone after 20 minutes, and that’s what I mean… It’s that whole Monday thing where my two mates call for me, and then we all go. It’s like a routine. Do you know, if they probably stopped coming, and I stopped going to the post office on a Monday morning [to get her benefit check], instead of… or whatever, just changed it round, it probably wouldn’t be still like, I won’t say appealing, but so the norm.

It is naïve to underestimate the power that routine has in the life of even a so-called “chaotic” drug user. There is a certain monotonous rhythm to the lifestyle of a dedicated drug user. The need to score brings with it the immediate need for cash, which often translates into shoplifting goods that can be easily and quickly resold. Then the call to a dealer, the buy and the eventual reward of the drugs brings the day to a close. Rinse and repeat. People fall into habits of place, activity and friends. Much as the habitual trip to Starbucks brings about a casual relationship with the baristas, the activities of habitual
drug users bring their own transactional friendships, friendships that may not be deep in nature, but still provide some measure of personal satisfaction and comfort.

For these women, the people that they used drugs with were a reciprocal source of drugs and funds, but not of emotional support. I asked Laura if she ever talked to the few friends she had who were also drug users and mothers.

Laura
You don't talk about anything like that when you’re on drugs. You’re just using and committing offences and you don't sit and have chats like you’re have a drink or a cup of coffee. Just everything stops when you’re using drugs.

Just as you would not expect your friendly barista to drive you to the doctor’s office, or listen with more than a cursory interest to your tales of woe, the transactional friend is concerned only with the smooth scoring and taking of drugs rather than with your social and emotional well-being.

The mothers in this study had little social contact with non-drug using friends. Though women were aware that friendships based on shared drug-use offered little else besides, they also felt unable to make friends with non-using mothers for fear of being stigmatized. Attempting to stop drug use meant cutting ties with old (albeit transactional) friends and bringing on a forced isolation to keep drugs away. Laura, below, was living in a hostel for homeless families with her partner while they awaited housing in a new and less relapse-inducing area where they would not know so many people. Shirley, a 40-year-old mother of three children (ages 14, 7, and <1), moved to her current home to be
nearer to her family and father and away from the drug scene that was causing her problems.

**Laura**

Yes, because at the moment I don’t really bother with anyone because everybody I know is on drugs. A lot of my old friends…well, not friends…drug associates. I’ve got a lot of friends who aren’t on drugs but I don’t really bother with anyone at the moment, I’m just starting to get back into socializing, because before it was all about grafting, scoring, grafting, scoring, that was my day. So I didn’t have time to, like, socialize with my friends and that.

**Shirley:**

Once you’ve got a friend, yes, then you’ve got about five of them, you know, and in the end all it is is trouble. Because, you know, they’re just arguing about drugs, and money, and drugs. Because I was never a bad person when I wasn’t on drugs, and when I got into it, I couldn’t understand all the underhandedness of it, all the sneakiness, and the stunts they do, and the dirty tricks, and they’re pinching your money, this, that and the other, and your drugs. And it’s bad, it’s worse than that, Abby, as well, you know, it’s just terrible. So that circle, it’s horrible, so I’d rather keep out of it, and keep myself to myself because that way I can cut down. And then when I feel that, good, I can cut down, and sort of push yourself further. “Well, I’ll leave it today, I won’t have it.” You know? That type of thing. Until you’re really craving that, you need it, but like try and go as long as you can. Whereas, if you’ve got someone ’round you and they’re wanting it so it’s making you [want it]. So in a way, that’s why I prefer to stay on my own. I’m not getting any younger, anyway, am I? And when I go round [to see my parents] I think my mum’s ashamed, and my dad. They think “When are you going to get off the drugs?” You know?

Thus their treat was, like all such guilty pleasures, problematic. Yet for those women whose lives held few other pleasures the logic of a quick smoke becomes apparent. For women isolated by drugs from “straight” people and isolated by poverty
from leisure activities that may require cash, transportation and possibly babysitting, the convenience as much as the enjoyment of transactional friends and their offerings adds to their attraction.

**Drugs as Rebellion**

Three of the women mentioned another reason for using drugs: rebellion. They felt trapped in their daily lives and either used, or were planning to use, to get back at or get away from their partners. Much like a teenage rebellion, a drug-use rebellion is both illicit and screamingly obvious, intended to provoke and punish.

The lives of the women in the study were highly constrained by their partners and their poverty. As other researchers have noted (Boyd 1999; Murphy and Rosenbaum 1999; Taylor 1993), there is a strong tendency toward traditional gender roles in drug-using partner relationships. Women care for the children and the home. Men go out. Traditionally, men would be going out to work, but the non-traditional nature of the men’s work in this context meant that men were as often in prison as in the pub. That did not prevent the men from placing limits on the women’s activities or prevent the women from letting them do so. However, in trying to fulfill their roles, some women chafed under these limits and looked for a way out. Drug use provided an escape without the need to go anywhere.

For Shirley it was a way to get back at, and away from, a physically abusive husband; for Zoe it was a punishment to her (non-using) partner for not getting a job and therefore causing her to start sex-working again; for Gina it was a fantasized escape from a small flat and a small baby her husband would not let her leave for long.

_Gina_
Sometimes I do feel like going off and… I don’t know, sometimes some Valium. You know? That’s how I’m getting. If you have a little smoke [of heroin] it would make things a little easier. And that’s not what marriage is about because I take my vows quite seriously, as I should. But I feel like he’s forcing me to, I feel like I’m being pushed into a corner so that I will end up doing something. Something is going to give because he goes out. I don’t mind him going to watch the football, and sometimes he disappears for hours. But he thinks that’s all right for a man to do. But what’s good for the goose is good for the gander. You know?

The idea that “making things a little easier” is “not what marriage is about” falls into the same category of idealized womanhood as Polly’s quote from earlier about “normal” women not needing a break from mothering. These women have embraced gender norms with a Victorian zeal and are disappointed to find themselves resenting the yellow wallpaper as much as their forbears.
“It’s never the same as what you think it would be. Is it? Never the same. You’re all sitting through thinking everything’s going to be hunky dory, when it’s not. There’s always something around the corner to surprise you.”

–Kristen (35 year old mother of 3)

There were few expressions used by the women in this study that so perfectly encapsulated their experience as “caught pregnant.” A woman may be caught unawares by the pregnancy itself, an unintended and possibly unwelcome surprise. She may be caught out by pregnancy in that it forces her to reevaluate and potentially change her lifestyle. She is caught up with her child in the bonds of motherhood. However, she also may be caught by the child’s father, who uses those bonds to keep her in his life and in his sway. Pregnancy also catches her in a web of services and interventions aimed at securing the best possible outcome for a drug-using mother and her child. However, should a woman not want those services, she may be caught trying to conceal her pregnancy and thereby risk being caught by a different range of services; those aimed at judging her fitness as a mother. She may then be caught trying to evade services that would seek to remove her child from her. Whichever interpretation one uses, being “caught pregnant” is irrevocably life-changing, even if those changes are not always what one would expect.
Becoming Pregnant

Becoming a mother is not simply the act of giving birth. It is accepting the obligation to assume care for another human being, not only to give a child houseroom, but to raise it into a competent adult through the careful administration of discipline, education and love. It is an emotional and financial investment that pays dividends only sporadically, if at all. While plenty of women enter into parenthood willingly and joyfully, for many others - drug-taking or straight, single or partnered - not all pregnancies are wanted pregnancies.

All but four of the fourteen women in this study became pregnant unintentionally. They were either unaware that they could get pregnant after long periods of infertility, or were not using contraception because they were not in “proper” relationships and had not planned on having sex. For women who felt that their circumstances were less than ideal, becoming pregnant brought on a number of mixed emotions. For Laura, a 31 year old mother of a 9 year old, a new baby brought tension to a new and faltering relationship. For Mary, her unexpected first pregnancy was the shock she felt she needed to get her life back on track.

Laura:

I’m happy to be pregnant but I’m not happy with my circumstances. I just wish everything would have been different, because we did want to wait till we’d been rehoused. We’ve been off the drugs for a while anyway, but to be stable and see how things were going. But it was meant to be, because she stayed there. The rest didn’t. I miscarried the rest. So she was meant to be.

Mary:

I was very shocked, but I was excited as well. It was like shock. Frightened and excited, because I was thinking, oh, my God. I was very bad on drink, and taking drugs as well. And then one side of
me thought, “Well, it will be good for me.” Because I’ve always wanted a child. Never thought I could have children because of my lifestyle. And then I just fell pregnant.

As Mary says, she did not think she could get pregnant because of her drug-using lifestyle. This is echoed in much of the literature on pregnancy and drug use, where women have reported that because they had not been menstruating, they assumed they could not get pregnant (Boyd 1999; Hepburn 2004; Klee, et al. 2002; Murphy and Rosenbaum 1999; Taylor 1993). Heavy drug use can lead women to become sub-fertile, meaning that although they are not technically infertile, due to the lack of decent nutrition and to weight loss concurrent with heavy drug use their bodies are not capable of ovulating or sustaining a pregnancy. When they cut down on their drug use, or maintain a treatment regimen, their fertility typically returns to normal, which may catch them unawares. Yet, when a drug-using woman already has older children, this argument loses some of its potency. She is clearly aware that she is capable of having children, so why would she not use contraception?

**Birth Control**

When we step back from drug-using women and look at the general population, we can see that underestimating one’s risk of becoming pregnant is a fairly common practice, not just among drug users. According to a 2008 Guttmacher Institute study of a nationally representative sample of heterosexual women of childbearing age in the US, one in four women is at “high risk of becoming unintentionally pregnant” because of gaps in contraceptive use. Many of these women were shocked to find themselves pregnant despite the fact that they were having sex while not using any birth control. To
further complicate matters, between 7 and 9% of all women using pill or injectable forms of birth control fall pregnant within the first year of use because of inconsistent or incorrect use. For condom users, the rate jumps to 18% (Frost, et al. 2008). A 2006 study of 316 Scottish women seeking abortions found that among women who did not wish to become pregnant, 16% were using no contraception while 44% were using contraception incorrectly or inconsistently (Schunmann and Glasier 2006). Researchers have noted that poor women, who tend to have frequent life changes such as changes in housing, partners, or employment, are overwhelmingly the most likely to report infrequent and inconsistent contraceptive use (Frost, et al. 2008; Schunmann and Glasier 2006).

For this study’s population of drug-using women, life changes – particularly in housing – can happen with alarming regularity. Homeless women and those newly out of prison are shuttled between hostels, bed and breakfasts and other short-term accommodations. Women living with family members can find themselves on the street when relationships break down over drug use or child rearing. Women and their partners may spend time in and out of prison, during which periods women feel they are unlikely to have sex and therefore forego birth control. This gap in protection leaves them vulnerable to unintended pregnancies when they or their partners get out of prison. Alongside this, drug use, though providing its own monotonous rhythm, leaves little room for preventative health care.

Gaps in use are not necessarily due to gaps in awareness. Women in the study were aware of birth control options, and the midwives worked hard to discuss their options with them during their pregnancies and immediately after they had given birth. Most commonly, women were encouraged by their midwives to use Depo-Provera. As a
single hormone injection that provides protection for at least three months, it is a reasonable option for women who do not want to take the risks of forgetting a daily pill or of relying on their partners to use a condom. In some cases the women themselves were intent on getting the injection despite the advice of those around them.

**Mary’s Mother**

I said to Mary, “Whatever you do, don’t take the injection.” Because I’ve known quite a few girls who have taken the injection and they’ve really put weight on rapidly, like two stone or something (28 lbs.). Really put weight on. So I said to Mary, anyway, I said, “Whatever you do, don’t have the injection.” So I thought, let me leave her to talk with the doctor… so I went out with [her daughter] and do you know while we were standing outside it just came in my mind, “I bet Mary’s taken the injection although I’d advised her not to do so.” And when she came out I said, “You did!” She was laughing. She said, yes. She did.

What is striking about the quotation from Mary’s mother is that her concern that Mary will put on weight seems to outweigh her concern that Mary will become pregnant again. Mary and her daughter, along with Mary’s 18-year-old sister and her sister’s baby, all live in their mother’s small but immaculately clean and well-appointed house. Mary and her sister both rely heavily on their mother for emotional and practical support. Mary’s long-term partner, an ex-punter several years her senior, has three grown children from a previous relationship. He lives an hour away from Mary and sees her and their daughter only on weekends. Becoming pregnant again would place a huge burden on Mary, her mother and her sister, in terms of both physical space and the toll that another child would take on their financial and emotional resources. Mary’s decision to get Depo-Provera was heavily influenced by a second unplanned pregnancy that ultimately resulted in a miscarriage.
Mary

As soon as I found out I was pregnant... because I missed that period, you know, I went to sort it out straightaway. To see, because I was going to go and have an abortion, you know. Until they told me it was twins, and I thought, “No.” You know, it’s not every day everybody gets told they’re going to have twins.

That Mary did not feel ready to take on another child is evidenced by her initial desire to have an abortion. It was only when she was confronted with the uniqueness of a twin pregnancy that she reconsidered. Still, Mary’s choice of a long-term contraceptive is an indication that she understands, perhaps better than her mother, that coping with another child while trying to maintain her recovery may be too much of a challenge. As mentioned in Chapter 2, families may not always be effective in giving the kinds of long-term support drug-using women need. Mary’s mother, despite having witnessed her daughter’s unwelcome pregnancy and subsequent miscarriage, sees only the short-term detriment of weight gain rather than the long-term benefit of family planning. Then again, Mary’s first pregnancy had been the catalyst for major sustained changes to her drug use, which previous family interventions and treatment attempts had been unable to achieve. In this light, one could understand why Mary’s mother may not have viewed another pregnancy as negatively as might be expected.

Other women, too, saw the value in the control given to them by long-term contraceptives and were willing to fight to get them. Rachel, age 26, below, sought Depo-Provera after unintentionally becoming pregnant with her fifth child just a month after giving birth to her fourth. Unlike Mary, though, Rachel wanted Depo as a stop-gap measure until she could be sterilized.
Rachel

I went to see my doctor and I said, “I need something.” I said about the Depo, in the meantime, till I get the sterilization done. And he said I can’t have it done yet because I have to wait until I stop bleeding and then have a normal period, and then do it like two or three days into that. And I said to him, you know, “I’m not willing to take that chance.” Because someone in the hospital told me that they will do it in exceptional circumstances. They will give you it there and then, you know, whether you start a period or not. So I put it to him, I said to him, you know, “I’ve been told that I can have it.” So he got all his medical books out and everything, and he said, “Well, I’ll give it to you now, then.” So he gave it to me there and then.

Sterilization is a somewhat dirty word among academics because of its shameful recent history as a tool of eugenically motivated policies aimed at culling the population growth of “undesirables”. In the US, up until the late 1970s, federally funded programs allowed for the sterilizations of hundreds of thousands of women (and occasionally men), who had been judged to be “unfit” or “mentally feeble.” Predominantly poor and from ethnic minorities, many of these people were forced, coerced or otherwise sterilized without their knowledge or full consent (Lopez 1993; Petchesky 1979; Schoen 2001).

More recently, a privately funded charity begun in California in 1997 has again thrown coercive sterilizations into the limelight. Project Prevention - formerly known as Children Requiring Caring Kommunities or CRACK - pays drug- or alcohol-addicted women and men up to $300 to get sterilized. “Clients,” as they are called, are paid the money only after providing proof of the procedure. In 2010 Project Prevention went global, expanding its operations from the US to the UK and hinting at a move into Ireland. These moral entrepreneurs push the idea that the physical effects of drug use
during pregnancy are the gateway to a host of social ills. The aim of the program is stated on its website, projectprevention.org:

The main objective of Project Prevention is public awareness to the problem of addicts/alcoholics exposing their unborn child to drugs during pregnancy. Project Prevention seeks to reduce the burden of this social problem on taxpayers, trim down social worker caseloads, and alleviate from our clients the burden of having children that will potentially be taken away. Unlike incarceration, Project Prevention extremely [sic] cost effective and does not punish the participants… Project Prevention does not have the resources to combat the national problems of poverty, housing, nutrition, education and rehabilitation services. Those resources we do have are spent to PREVENT a problem for $300 rather than paying millions after it happens in cost to care for a potentially damaged child. (original emphasis) http://projectprevention.org/objectives

Clearly, the goals of Project Prevention are to stop the “wrong” kind of people from having the “wrong” kind of babies. Others have assessed the program more fully and adequately than I can here (see for example Gregory 2010; Simmonds 2006 and The Journal of Law in Society, 2003 volume 5 issue 1 which is dedicated entirely to critiquing CRACK), but I mention the program to point out why there is a (justifiable) knee-jerk rejection of sterilization as birth control among many activists and advocates. If sterilization inherently allows the powerful to limit the freedom of the powerless, it is inherently abusive. But what about Emma and Rachel, who actively sought sterilization?

**Emma**

I’m getting sterilized this time, because I’m too old now, I’m 41. [My partner is] out [of prison] now in August. I’m 41 now. I’m too old and it’s dangerous, anyway. I don’t want any more kids. I mean I’ve got six and, thank God, they’re all still with me.
Rachel

As soon as I found out I was pregnant I planned to have it done. They asked me in the hospital, I wanted them to do is straight after, but they can’t, unless you have a C-section, because they’re already operating on you, they can do it, but other than that you’ve got to go on a waiting list, and wait for that, so I’m waiting for that to be done at the moment, because I don’t want any more children. You know, Patrick says, you know, he said to me, you’ve got to be sure because, God forbid, if anything happened and you met someone else, you know, you might want more kids, but I don’t, I’ve had my kids, I’ve done it since I was fourteen, so that’s me done now, I’ve done my baby thing.

When Emma says “it’s dangerous, anyway” she is referring to the severe, life-threatening hemorrhaging she experienced during the birth of her sixth child, rather than to any danger linked to pre-natal drug use. But most telling is her comment about having all her children still with her. In other words, she has managed to keep six children away from social services and out of foster care. Having another would be to tempt fate, a risk she is unwilling to take.

Equally, Rachel does not want to take the “chance” that she will unintentionally get pregnant again. As she says, she’s “done her baby thing.” She and her partner live in a tiny, crowded, dingy flat with barely enough room for them, much less their two small (but growing) children. They have been trying to get rehoused for over a year but no properties have become available. Rachel rarely sees her other three children, who live with her mother several hours away from Manchester. Taking control of her fertility is one means of taking control of her life, much of which is out of her hands.

According to some, sterilization is a choice, but only insofar as it is always a bad choice made by people who have no better ones, as Rosalind Petchesky stated in her
scrutiny of the federal sterilization regulations in the US, “clearly, even when voluntary, sterilization is often chosen in a context of heavy structural constraints” (Petchesky 1979:31). Similarly, Iris Lopez, in her study of Puerto Rican women in New York, said “given a woman’s conditions, in some cases, sterilization may be the most reasonable decision they can make” (1993:309). Julie Gregory, in her analysis of Project Prevention, argues that “while long-term birth control methods are not compulsory for substance-users ‘of child bearing age’, blame and risk discourse related to prenatal drug-use — including the fear of incarceration and/or of losing one’s child(ren) — are so pervasive that they might as well be” (Gregory 2010:58). In other words, the thinking goes, no one would choose to permanently end her fertility if she didn’t have to.

However, I would argue that for the women in this study, sterilization was seen as a valid and valuable tool for limiting their reproduction and was not chosen under the severe constraints envisioned by others. First, eugenic sterilizations never caught on in British national policy as they did in the US (Macnicol 1989). Women in the UK do not confront the same legacy of coercion and abuse as women in other parts of the world. Also, all forms of birth control are free under the National Health Service. So unlike in the US, where insurers may pay for a sterilization in full, but may decide not to pay for the birth control pill or other short-term methods, in the UK there is no added financial incentive for women to choose the “cheaper” sterilization option.47 Furthermore, women in the UK do not face the same threat of arrest for prenatal drug use as their US counterparts and are therefore less “at risk” than women in the US who become pregnant.

47 According to the website for Planned Parenthood, sterilization in the US can cost from between $1500 and $6000, whereas the pill costs between $15 and $50 per month, plus the cost of annual doctor visits. (http://www.plannedparenthood.org/health-topics/birth-control)
Johanna Schoen, in her excellent examination of women who sought sterilization under the auspices of the North Carolina Eugenics Board, points out that it was “not the technology of sterilization that determined whether women saw the operation as repressive or liberating, but the context in which this technology was embedded” (Schoen 2001:134). For a drug-using woman who has had enough of childbearing but is faced with the likelihood of additional unintended pregnancies, reliable and permanent control over her fertility can be empowering.

Likewise, the tendency to view a permanent end to fertility as negative fails to recognize that fertility is not an isolated process. Fertility generally leads to children. Children, in turn, require significant investments of time, money and emotion that few parents have in endless supply. It is a rare group of individuals that does not need to make some calculations about the optimal number of children they can reasonably support.48 For women in this study, long-term contraception and sterilization can be a means of asserting control over an intimate and fundamental aspect of their lives that may have previously been far outside of it.

**Men’s Role in Pregnancy Decisions**

Somewhat logically, discussions of pregnancy tend to center on women, but little attention is typically paid to the role men play in the decision to become pregnant or to carry an unwanted pregnancy to term. At the other end of the spectrum from empowered women controlling their fertility is a significant group of women whose male partners

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48 There is a tendency (sparked in part by the legacy of coercion and abuse) to view rich women’s choice of sterilization as empowering, but poor women’s choice as necessarily repressive (Petchesky 1979; Kluchin 2009). When we want to argue for the wider availability of birth control and abortion, we talk about the negative health implications of having to “endure” multiple pregnancies, but when we talk about sterilization, we talk about the detriments of limiting women’s freedom to choose multiple pregnancies.
will not allow them to use birth control at all. These men insist not only on sex without
condoms, but also that there be no other form of contraception used, even hormonal.

Women I spoke with throughout the fieldwork voiced the suspicion that men felt a need
to publicly “stake their claim” to a woman through paternity. Others noted that may be
because of the way men can utilize the vulnerability of pregnancy and children to control
their partners. Gabrielle a midwife with MSMS, has watched this form of control first
hand with her clients.

Gabrielle, MSMS Midwife

There was a girl who sex-works who had at least two pregnancies since I’ve been here, and they’re
not her choice. It’s his way of controlling her and making sure that, you know, she’s where she
needs to be. If he has her children, she has to go out to work, because she doesn’t know what he’s
going to do to those children if she doesn’t bring that money in. So it is control. I think it’s much
harder, as well, to leave with two or three children than it is if you haven’t got any.

Emma, the 41 year-old mother of six children, was routinely battered by her husband, but
never left him, in part because of the practical difficulties leaving with all six children in
tow. Not only would she have had to gather up all of her children and their belongings,
but there simply wasn’t anywhere else for her to take them.

Emma

I don’t know why I was so weak at one time, but now I’m not, maybe it was the whole drug thing.
I mean, the thought of actually…I kept thinking, “Right!” Because I used to be, get battered quite
a lot by Peter. There wasn’t a week I didn’t have a black eye and all that. But, and I’d think,
“Right! Fuck it. I’m going. I’m going!” But the thought of actually getting all of the kids’ stuff
together is so daunting. And, you know, where am I going to go? You just forget about it.
But not all women take it lying down, so to speak. The MSMS midwives told me of a woman whose partner refused to use birth control or to allow her to use any. But rather than have more children, she conspired with the midwives to get the health care she needed. The midwives contacted her partner’s probation officer, who agreed to give them advance notice of his probation appointments, and to make sure those appointments were extra long. Then, while the partner was with his probation officer, the woman was able to slip into the family planning clinic and get her shot of Depo-Provera. In other instances, women tell their partners they are going to see their drugs workers for a methadone prescription and get contraception at the same time.

Kate, MSMS Midwife

We have one woman that comes here, don’t we, to this contraceptive clinic. But she comes here because her partner thinks she’s coming for a [methadone] prescription. So she comes for her prescription and she gets seen for the contraception, because he won’t allow her.

In these cases, a long-term contraceptive like Depo-Provera or Norplant allows the women to control their fertility without requiring the cooperation or knowledge of their partners. When the MSMS midwives counsel women on the use of long-term birth control methods like Depo Provera (though never, in my experience, were women advised to get sterilized), the midwives are basing their advice on their experience with hundreds of women in similar circumstances who have found long-term birth control to be beneficial. MSMS midwives were the most vocal and active advocates for drug-using mothers I encountered. It would be a mistake to view their counseling as coercive or an attempt to limit “undesirable” reproduction.
Unsurprisingly, men were able to influence women’s pregnancy decisions in more subtle ways than outright bans on contraception. Several of the women in this study said that they become pregnant “for” their partners, or decided to continue an initially unwanted pregnancy “for” them. Of the four women who had intentionally tried to become pregnant, each had felt pressure from her partner to have a child “for” him, often despite the fact that they already had older children and were not planning to have more. Gina, the 31 year old mother of 3 other children, felt that her new husband would have “by hook or by crook” found a way to get her pregnant. She even doubts whether they would still be together had she not given in to him.

**Gina (Partner has one other child)**

If we didn’t have [our daughter] now, that’s if we were still together, [They were still together as of the end of the study] he would still be going on about having a child. He would, by hook or by crook, one way or another, have a kid with me. He wanted a child with me. I don’t know whether it was all about his ego or what. To be honest, I don’t even know if we’d be together. We probably would be together but I think he wanted a kid and that was it. As simple as that.

As mentioned above, women and service providers I interviewed, and those I encountered during observational fieldwork, voiced the suspicion that men were using pregnancy as a means of binding women to them and limiting the women’s mobility and availability. This was particularly true for women in abusive relationships, who found the prospect of escaping from a batterer too daunting to attempt with children in tow. Men encountered in this study often had other families with two or three different women, between whom they alternated as needed. Nine of the women in the study were with partners who already had one or more older children with other women.
Kate, MSMS Midwife

I think it’s all about keeping your options open. I’ve got a family at the moment where the children have been removed. Now he has two other women with children. So these children have been removed. So, it’s not going to affect him as much because he knows he’s got children over here. So he just goes and moves in with her, and he can get his daily dose of children then, can’t he? But if it goes sour with her, she gets fed up with him and his drug-taking, womanizing ways, then he can go to this one. And she’s only 17, and she doesn’t know anything from anything, and she’s got one of his children as well, so he goes to her for a bit. But once he gets fed up of her being childish, then he’ll come back to this one. You know, it’s not because they’ve got the children and they want some contact with the children. It’s what they’re going to get out of it. So it’s a roof over their head, and it’s money in their pocket, or drugs that they can use, or food in their belly, or whatever it is. Sex, or whatever it is. That’s what I feel that I see, is that they will go with whatever need they need next.

It would be cynical to argue that men’s sole motivation for getting their partners pregnant was a need to control them. There are men in this population, Vicky’s partner among them, who are dedicated and devoted fathers. Nonetheless, there are still more who are contented to leave the entirety of the child rearing to their female counterparts. Indeed, given the way some of the male partners in this study navigated their parenting relationships, it is difficult to see what benefit men get out of pressuring women to have “their” babies apart from bragging rights.

Suzie (Partner has eight other children)

That’s what I said to him. I went, “You wanted it more than I wanted it.” And now that she’s here and that he just… people just said that he did it to trap me, you know, so I can’t go anywhere. Like go and meet someone else, sort of thing.
Even women who had seen themselves as being in “stable” relationships during their pregnancies often saw the men drift out of their lives as the babies got older. In at least one instance I was aware of, the drift began during pregnancy. Laura’s partner slept with a 16-year-old girl who lived in the same homeless families shelter as they did. Despite his infidelity, and perhaps because she was carrying the baby they had tried so hard to conceive, Laura stuck by him throughout the ensuing statutory rape investigation and his subsequent prison sentence for drug dealing. Overall, nine of the fourteen women’s partners became less and less involved in their lives and the lives of the children over time, sometimes within months of the baby being born. Four of the women were still living with the father of their child one year after the birth, and one woman (Emma) expected her husband to return home when he got out of prison. In all cases, promises of financial support were rarely carried through, even in cases like those of Gina and Shirley, below, who had babies “for” their partners.

**Gina (Partner has one other child)**

I just thought he would have been more of a hands-on dad and I thought that he would …all the promises he’d…words are cheap. And I thought he would have made more of an effort for things, but he hasn’t and there’s only myself. I can’t…that's not a slight on him. I’m big enough to make my own way in life, but she’s both our baby and I’m his wife. I know he’s my husband and I try to…. we’ve had this argument a lot. I try and be a good wife. He always has a hot meal. I try, in this horrible little flat, to make sure there’s clean clothes, the baby is always clean, the place is always somewhat tidy. And sometimes I think he doesn’t keep his side of the bargain and that really, really gets me down.

**Shirley (Partner has no other children)**

It’s been hard, really. He said he’d be there for me. Like he’s been here, he’s been here every day. He’s just got a job now, he’s working again. But like, when I had her he’d be here most days,
every day helping out. But then it was like dying off. So it’s like, just me all the time doing it. And
I was tired, really tired. I felt like killing him. Sometimes it changes a relationship. It does, Abby.
It changes it for the worse as well.

For men, an added bonus of fatherhood is the provision of a home that would not
otherwise be so readily available. As mentioned earlier, all of the women in this study
were on some form of public assistance, usually income support, but also housing
benefits as well. It is worth recalling that it is women and children, and not necessarily
men, who get priority housing as a result of pregnancy.\(^{49}\) One aspect of housing benefits
is the requirement to maintain regular, if only nominal, payments on a rental property. So
long as a woman maintains some degree of consistency in her payments, she will be able
to stay in her accommodation. Women with children have a strong motivation to maintain
their homes and to pay the rent required to keep them. When men drift out of women’s
lives, they can be reasonably secure in the knowledge that their female partners will work
hard to retain a place to live, and consequently retain a place that they, the men, can drift
back into.

\(^{49}\) There is an astounding “fact” quoted by lay people and tabloid newspapers alike (Seargent 2009) that “women on
welfare have babies \emph{in order to} get more welfare money or a bigger house.” I cannot count the number of times
otherwise intelligent individuals claim that the problem with the UK welfare system is the wily females abusing the
generosity of the state by having babies to get rich. It echoes the claims routinely made in the US about “welfare
queens” procreating for more money (Simmonds 2006). This is not only a phenomenally ignorant assertion; it is both
contradictory and insulting. It assumes that women are smart enough to try and game the system for an extra £13.40 per
week (hmrc.gov.uk/childbenefit), but that they are too stupid to realize that diapers cost £5 per week, baby formula
costs £10 per week, and clothing, toys, baby equipment and transport will all cost extra as well. It assumes that women
have no intention of caring for their children because they are just “in it for the money.” Apparently, women on
benefits are willing to go through pregnancy, childbirth, the terrible twos and the glorious teenage years all for the
princely sum of £53.60 per month, yet are planning to let these highly profitable babies run feral in the streets without
clothing, food or any parental input. (See also Susan L. Thomas, \emph{Ending Welfare As We Know It, or Farewell to the
Rights of Women on Welfare?}: \emph{A Constitutional and Human Rights Analysis of the Personal Responsibility Act}, 78 U.
\textsc{DET. MERCY L. REV.} 179, 195 (2001).
**Pregnancy Made Public**

A large number of services coalesce around drug-using women when they are found to be pregnant, and not always in ways that the women see as beneficial. For some women, the concentration on them during their pregnancy further highlights how invisible they are the rest of the time. As one woman said to her midwives, “I’m only important when I’m pregnant.”

A question repeatedly asked by the MSMS midwives about a new client was whether or not she was “known to services.” Disadvantaged women in Manchester can access several social welfare services to assist them with everything from housing and financial benefits to health care and schooling for themselves and their children. Many of the services are low-threshold, meaning that the workers make it as easy as possible for women to access the services. Workers can visit women in their homes or hold joint clinics in service centers the women may already be attending, such as a GP’s office or a Sure Start Children’s Centre. Workers in these fields quickly become familiar with each other, the women, the women’s partners and the peculiarities of the neighborhoods in which the women live. Particularly because many of the women have complex needs addressed by multiple agencies, workers naturally form casual working relationships with workers at other agencies (sometimes if only to berate one another for not following through on a specific client’s needs). However, a commitment to “joint working” was being championed by the government when this research was conducted, which meant that agencies were actively encouraged and empowered to share information about clients.
If children are to be protected from harm and their welfare promoted, effective joint working between agencies and professionals with different roles and expertise is required. (Vulnerable Children's Service 2007)

Joint working, particularly around child protection issues, came on the heels of the high profile case of Victoria Climbié, an eight-year-old girl who was systematically abused and ultimately murdered by her aunt and her aunt’s boyfriend, who were her guardians. In the government inquiry into Victoria’s death, it was found that there were twelve separate occasions on which the authorities could have intervened, but failed to do so (BBC.co.uk 2002; Littlemore 2003). The Children Act 2004, which aimed to reform children’s services, was implemented as a direct result of the inquiry. A major priority of the act was to mandate early intervention into potential child protection cases, and to encourage interdisciplinary coordination between services.

**John, Social Worker**

When we’re involved with a family we’d be, if you like, the lead professional. We’d be coordinating all the other agencies to make sure that they’re involved. We’d be the ones who’d be organizing the case planning meetings to make sure that different agencies are keeping to the plan that’s been organized. And also making sure that the family are engaging with all agencies. It could be that [the family] are, you know, they’re just not willing to engage. We check on a number of cases, you know, the families just, they’re not willing or they’re not able to engage. And in those circumstances you need to look at going down a child protection route, which, you know, you’d have to organize a case conference and follow the child protection procedures really.
Joint working is valuable to women in many ways, and previous research has found that drug-using women do want more help accessing and navigating social services. (Chavkin, et al. 1993b; Clark 2001; Klein and Zahnd 1997; Sun 2006). But joint working also creates a more efficient surveillance network of professionals monitoring women’s reproduction. For example, if a woman turns up at a hospital to give birth, but she has not previously “booked” with that hospital, meaning that she has not had her prenatal care through that hospital or its midwives, the hospital can check for alerts about her within the Local Supervisory Authority database. This is a nationwide database predominantly used to share information among midwifery services about best practice. However, it can also be used to track women who have been flagged by service providers in their area as likely to have their babies removed at birth by Social Services, and who might try to elude services by giving birth at another hospital. Hospital workers can then tell the creators of the alert where a woman and her child are, and action can be taken to remove the child from the woman’s care. While one can certainly see the benefits of this system from the perspective of the social workers who are trying to protect vulnerable children, one can also see how a woman might feel cornered by the level of Big Brother-esque scrutiny.

In Manchester, any pregnant woman known to be using illegal drugs, in drug treatment or misusing alcohol, is to be referred to the MSMS midwives. Any one of the service professionals working with a woman can make a referral. From there, a woman’s pregnancy is transformed from a relatively private event into a very public one. Though a drug-using woman may refuse the specialist midwifery service, her refusal to engage is suspect, further raising red flags about her ability to parent. Her status as a drug user
raises questions about the health of her pregnancy, her fitness to parent and the environment into which she may be bringing a child, questions that are not present for a non-drug-using woman. She is transformed from a “client” to a “pregnant client,” marking her at once as both privileged and problematic.

Pregnancy is privileged because it fast-tracks a woman for access to drug treatment, housing and health care. If she was not previously “known to services,” her pregnancy means that now she will be. The normal wait for drug treatment may be anywhere from two weeks to two months, but a pregnant woman can be enrolled in treatment and started on a methadone script within a week. Pregnant women also get priority enrollment in residential treatment programs for drug and alcohol detoxification. A woman moves from being considered primarily a “drug user” to a “pregnant drug user,” with the pregnancy taking primacy over the drug use in the eyes of providers, who are now forced to consider the woman, rather than just the drugs. Pregnancy also adds urgency to women’s other health concerns, such as poorly managed diabetes or high blood pressure, which might be overlooked when drug use is the central focus. Similarly, homeless pregnant women are fast-tracked for properties or moved into accommodation for homeless families, which are typically larger, cleaner, and more private than shared hostels for single homeless women.

One program, called the Vulnerable Babies Service (VBS), is meant to coordinate all these services for women and facilitate communication among them. Developed initially to combat the abnormally high infant mortality rate in Manchester – 8.6 in Central Manchester vs. 5.2 in England overall (Bliss 2006 compiled from Office of
National Statistics figures) – VBS is used to support women whose children are considered at high risk of being referred to social services. The women do not have to be drug users. They may be homeless or have mental health issues or any number of factors that could be seen to place their children at risk. All of the agencies working with such women, including drugs workers, health visitors, housing workers, midwives, probation officers and the police, are brought together to make an initial care plan for the women and to ensure that all the agencies are talking to one another. Like many other services, participation in VBS is by consent. However, many of the midwives found themselves in an awkward position when trying to engage women in the service because of the participation of the police. The VBS asks the police to share any information they may have about a woman, her partner, and potentially others who may be living in the same house as she is. The midwives and other workers found the police information to be valuable, particularly with reference to the potential risks to the child posed by a woman’s partner, but they were uncomfortable telling women that they would be talking to the police. As a result, the MSMS midwives told me that they often did not mention the police involvement in VBS when asking women to engage with it.

By underplaying the police involvement in the VBS, the midwives, while violating the concept of informed consent, are also signaling their own discomfiture with the dual role they play as both advocates and enforcers. Each of the professionals involved has to balance her desire to help a woman, often someone with whom the

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50 There are several different readings of the ONS data, some of which put the infant mortality rate closer to 7.2 (Manchester Public Health Annual Report, 2006; APHO and Dept. of Health, 2007). However, the Bliss figures received the most media attention and were apparently the catalyst for the formation of the Vulnerable Babies Project and other local initiatives aimed at reducing infant mortality in Manchester.
professional has developed a close relationship, with her duty as agent of the state to protect the welfare of children.

**Juliet, Drugs Worker**

So this woman was really emotionally…she was like a child. She’s had one little boy removed previously. Then she got pregnant again. And of course, inevitably, she lived with a really horrible man who was violent and abusive. So she’s with this bloke who was kind of basically abusing her and bringing his friends round. So she’s got these two boys. She’s not parenting them properly because she’s off her face a lot of the time because she’s blocking it all out. And [the professionals] are all desperately trying to support her. Meanwhile the boys are, you know, are displaying sexualized behavior, and all sorts of things. Then she gets friendly with this bloke who is a taxi driver. And she says, “Oh you know, he’s great because he comes and takes the boys out.” And he ends up sexually abusing the boys, so she loses the boys because of the taxi driver… I really liked her, and wanted her to do well. Desperately wanted her to do well. But we left it too long because of that. We all really liked her. We were all desperate for her to do well, but it was inevitable.

Having a child taken into care by social services made the professionals feel they had failed the women they were trying to help, and made the women feel they were being punished. As one drug-using woman, who had been sexually abused by her father and physically abused by her husband, told one of the MSMS midwives, “I’m to blame because my dad fancied me instead of my mum; I’m to blame for letting my husband beat me up. Now, I’m to blame if there is anything wrong with this baby. Why can’t something be his fault for a change?”

At each point of contact with a woman who is a mother, the social welfare agencies involved with her must ascertain whether or not she is putting her children at risk. In conversations I had with professionals at various agencies, from probation to drug
treatment, workers would often use the phrase, “since Victoria Climbié” when describing their processes of relating to women with children. Referencing the worst-case scenario of a child murdered by her caregivers, staff showed that they were acutely aware of the stakes involved when working with children. As the case above highlights, this can be as difficult for the workers in these agencies as it is for the women. Workers frequently visit women in their homes, witnessing firsthand the love these mothers have for their children and the challenges they are trying to overcome. Making the call to social services to have a woman’s parenting investigated, knowing that it may result in having her children removed, places a unique burden on the workers concerned.

Kate, MSMS Midwife

I feel that sometimes people view us, they look at us and they think that we want, that we are there for that woman. And we are going to fight tooth and nail for these children to stay with their mother. And quite often that’s, in some cases it’s the reverse. We’re saying, “Please don’t let her have this baby. I can’t go to bed tonight knowing this baby’s there and not being cared for.” I think sometimes that’s other people’s view of us. And so sometimes I think they’re quite guarded in the information they give us, and how far they’re going to let us in. Because they assume that we’re going to be all out, particularly social workers, I think, that we’re going to be all out for this woman to take this baby home. So, you know, it does matter, the circumstances matter, and you can’t ignore those circumstances. But it doesn’t stop you feeling devastated, and really, really upset when a woman has a child taken off her.

Knowing that they are being monitored, some drug-using women attempt to evade scrutiny and intervention by concealing their pregnancies for as long as possible. One of the women in this study, Rachel, who was already under the care of the midwives, health
visitors and drugs workers after the birth of her son, concealed a second pregnancy until she was 32 weeks along.

Alice, Drugs Worker

I know there’s fear around Social Services. I’ve had at least two female clients who have hidden their pregnancy pretty much till eight and a half months because of previous Social Services involvement. It’s like, “Well if Social Services find out I’m pregnant, I’m going to get all this attention, and I don’t want it.” So they’ll wear big baggy jumpers, and coats. And two women in particular, and for two pregnancies each, kept it secret till about eight, eight and a half months. And there was a woman where the social worker actually phoned me up and she said, “She keeps wearing these big baggy coats. She’s done it before. I’m sure she’s pregnant. Try and speak to her about it.” And I tried, and she denied it, denied it and denied it, and then at about eight months she came and she was like, “Yes, I’m pregnant.”

In the cases Alice describes above, each of the women had had a previous experience of losing a child to Social Services. In attempting to evade surveillance, they unwittingly confirmed official suspicions about their unfitness to parent and lost their children anyway. In Rachel’s case, she already had one child under the age of one living with her, and three older children living with her mother. In concealing her pregnancy from the services already engaged with her, it is possible she felt there was too much intervention in her life already and she wanted to avoid any more. It is also possible that she felt the services had nothing more to offer her, so she did not see the benefit of involving them in her pregnancy. Whatever her reasoning, by trying to keep outsiders away from her pregnancy, she ensured their closer involvement in her parenting.

Providers who had noted, but had not been alarmed by, her return to sex work and lapses in picking up her methadone were now, because of her non-engagement, murmuring
about her ability to care for two small children and considering whether or not to place the children on the at-risk register.  

Changes to Drug Use During Pregnancy

Despite their justification of their drug use, all the women in the study, at some point, expressed a desire to be “normal.” Not just to feel normal, as mentioned earlier, but to have a “normal life.” Or as Gina put it, “I want to just be a normal woman. That’s what I aspire to be.” A normal life was one defined by stability in housing, bedtime routines, love, or “just everyday things” like having enough food. The route to normalcy was through drug treatment.

Treatment has a rather variable meaning in the UK. While there are the classic residential treatment programs that some may envision when they hear the phrase ‘in treatment,’ more common for heroin addiction treatment are outpatient prescribing and counseling services. It should be remembered that a range of inpatient and outpatient services are offered for free on the NHS, though one can choose to pay for more exclusive services if so desired.

Overall, drug treatment for the women in Manchester, and for much of the UK, is a shorthand for methadone maintenance; a legal opiate substitute that replaces the highs and lows of street heroin with a slow steady hum of medication. Being on methadone is not like being drug-free. In many ways it is like putting the women on Prozac to smooth out the emotional ups and downs of a depression. As one drugs worker put it, methadone

51 The at risk register is a registry of children for whom there are child protection concerns, but who are not yet in need of immediate removal from their parents (or caregivers). These children, and their caregivers will be closely monitored by social services to ensure that recommended improvements in lifestyle, environment and/or parenting are carried out. If the progress is satisfactory and sustained, the child will be taken off the register and the monitoring will stop. If not, the child will be removed and placed in foster care.
“cotton wools” emotions and mental health problems so they are less damaging. It doesn’t fix them. Due to the nature of substitute prescribing, being “in treatment” is not an isolated event. Treatment could mean taking methadone for decades, as was the case with Vicky, while using more or less street heroin on top at various points when things became more or less chaotic. It is less that people enter or leave treatment, but more that they re-engage with treatment after a period of instability.

Outpatient treatment services for heroin predominantly offer substitute prescribing and one-to-one counseling. The content of one-to-one counseling can vary from service to service and from worker to worker, but commonly workers spend around 15 minutes per client trying to assess the client’s current levels of use, what the triggers are for repeated drug use and what steps the client may be taking toward overall stability. The worker can then adjust the methadone dose; offer some help with navigating the maze of the housing and benefits authorities and “signpost” the client on to other services. With an average caseload of 80 clients, each to be seen for fifteen minutes every two weeks, there is not a great deal of room for meaningful psychosocial interventions. Many workers are careful not to call themselves counselors because they are not formally trained in counseling. Juliet, a drugs worker, told me a story of one woman who had a history of childhood sexual abuse and had lost her children into foster care and who “went off the rails” after a “counseling” session.

She went and had counseling where she sat for an hour and talked about how awful it all was, with not much kind of direction really about how to take that forward. No one to go and talk to at home. And it just kind of raked it all up for her, and she found it too upsetting. So I think when we have a client, we have to be very careful what we touch on if we can’t do much with it.
Not being able to “do much with it” is a consistent problem for the workers and the women in treatment. For many of the women, the problems they have are not in their past, they are waiting for them when they get home. For the workers, without the time or the training to engage women in constructive work over the long term, they cannot give the women the tools they need to tackle the problems at home. At the same time, workers also questioned the women’s ability to be able to effectively utilize formal psychological counseling, or any type of intervention that required intellectual engagement and self-reflection.

Juliet, Drugs Worker

We’ve got somebody who provides [Cognitive Behavioral Therapy], but only one afternoon a week, so I’d certainly use that quite a lot, for people I think have got the insight to be able to go and have CBT and use it practically.

For the drugs workers the goal of treatment is stability. Stability is defined as being on a stable dose of methadone, not as abstinence. The idea is that the stability on medication will produce a knock-on effect of overall life stability.

Matthew, Drugs Worker:

If somebody is using between one and six bags of heroin a day and they’ve got to fund it somehow, and they probably can’t fund it through benefits, so you can only go so far with borrowing from family and friends, at some point you’re either going to have to either get into shoplifting, or quite possibly into prostitution…Obviously there are a lot of risks to themselves in getting involved in criminal activity. If it’s acquisitive crime then there’s the risk of being caught and being incarcerated, and losing their liberty, and having to have a child in custody, etc. In the case of sex workers, obviously [there is] risk in terms of safety, their own safety, health problems, etc. So I think one of the most effective things that substitute prescribing (methadone) does is it massively reduces the need to go out onto the streets, or to get involved in shoplifting.
The drugs workers felt that the focus on stability and harm minimization, rather than a more criminal justice approach to the drug problem, was as much an economic choice for the government as it was a moral choice. They saw the government’s rationale as stemming from the idea that chaotic drug users pose a public health risk and a social threat. Getting users into treatment gets them off the street and into clinics, reduces the amount of needle sharing and HIV infections and reduces the number of crimes committed to fund a habit. While the workers broadly agreed with that assessment of the effects of treatment, they also saw the almost single minded focus on getting people into treatment as a numbers game to fulfill government targets. As Juliet said, “We’re very good at getting people into treatment. We’re not very good at helping them to move on.”

As clients begin to engage with services, the workers get a sense of the other needs a drug user might want addressed to help maintain that stability. The worker can then ‘signpost’ or refer a client to other services, like housing workers or alcohol workers, who can help the clients get more of their lives under control. However, a phenomenon described to me by the drugs workers, was the ‘I’ve got a taxi waiting’ tactic of some of their clients which belies one’s assumptions about what it means to be ‘in treatment.’

**Alice, Drugs Worker:**

A lot of people coming into treatment don’t really want help. And the thing we hear on a daily basis is, “I’ve just come to get my script. I’ve got a taxi waiting. I can’t stop.” And that’s a really, really common excuse. And if people don’t want to engage with us, and they don’t want to listen to what we’ve got to say, and they don’t want advice, they just want their methadone prescription. So, no, we probably don’t have a great impact on those people. They want the methadone. They don’t want to stop using, but it helps them get a bit of stability. It’s free. It’s long lasting. But
they’ve no intention of stopping using. They don’t really want to address their drug use. Whereas other people really, really do, and they’re the people that I think we can have a real impact on. People that do actually want to sit down and talk to you for 10, 15 minutes. Who want to take up the other services that we can refer them to. They do say, “Oh yes, I’ll see the stimulant worker. Yes, I’ll see the alcohol worker. Oh yes, I’ll go for that acupuncture.” Take on board all the advice we give them, and I think, yes, we can have a real impact on them.

**Juliet, Drugs Worker:**

There’s a whole kind of joke within drug services, and I think there was even a conference called, “I’ve Got a Taxi Waiting.” Do you know what I mean? “I’m two days late for my script, but I’ve got a taxi waiting, can you help me now?” You know, it’s that kind of, “I want it and I want it now.” syndrome, and “I don’t want to have to take responsibility.”

This attitude toward treatment was hinted at by Rachel who mentioned that early on in her drug use she would enroll in treatment only when her partner wasn’t there to help her fund her habit. ‘When he went to prison that’s when I’d get off it. I’d get on a script then, because I didn’t know how to shoplift and things like that. And I didn’t have money. So I’d get myself on a script.’ In other words, though the clients are technically ‘in treatment’ they may not necessarily be committed to a goal of becoming drug free. What drives a person to enter treatment in the first place? As mentioned above, the desire to be “normal” is a powerful theme in the women’s narratives. But is it the case that they don’t see themselves as “abnormal” until they become mothers, or is it that the lack of normalcy is not, in and of itself, a motivator? Although much of the literature on pregnant drug users singles out pregnancy as a unique window of opportunity for getting women into drug treatment (Ashley, et al. 2003; Boyd 1999; Boyd 2004; Chavkin, et al. 1993a;
Daley, et al. 1998; Knight, et al. 2001), the women in this study had multiple treatment attempts behind them well before they were caught pregnant. Women in the study had been using heroin for an average of fourteen years and had tried some form of treatment an average of five times by the time I met with them. It was not always formalized methadone treatment that they tried. Mary said she had been “kidnapped a good few times” by her family and forced to do a detox locked in her aunt’s bedroom, while others bought methadone on the street or tried to devise their own detox regimens at home.

Shirley

Because I did a detox myself last year at home, on my own… it took me eight weeks, it was murder, and all I took was Paracetamol (Acetaminophen), I did well. It was murder, I was like cracking up, I don’t know how I got through it when I think, I just blank my head through the thought of it now.

Pregnancy was certainly a reason for their most recent treatment attempt, but prior reasons for attempting treatment varied. A common theme was getting ‘fed up’ with the lifestyle. As the women said, the pleasure of the drugs wears off fairly quickly, but the effects of constant use on your body, your finances and your friendships are long-lasting. When women reached a point when the need for the drugs and the things they needed to do to get them became too much, they would try to stop.

Laura

Things going wrong. People coming in the property just taking the micky [taking advantage]. The lifestyle. The pinching [stealing], I just didn’t like the way my life had become. It was like I had hit rock bottom.
**Emma:**

I don’t know, just the thought of getting nicked and that. Because I used to be ruthless…I mean nothing like robbing old women, I’ve not done anything like that. I’ve never been a prostitute. It was just shoplifting, like checks, and fraud, and nothing that actually hurt people physically. I don’t know, I just woke up one morning, yes, honest to God and the thought of actually going out grafting terrified me. And I was ruthless, like I said, I’d be out, I went all over the world shoplifting, I was terrible. And then, I don’t know, honest to God, I was like that (shaking) at the thought of it. And I thought, ‘Thank God for that.’ And I knew it would happen to me one day, and I was just so glad.

Emma says she “knew it would happen,” that one day she would no longer want to use. Many of the women, when they talked about drugs and treatment, described this dual state of continuing to use while hoping one day that they wouldn’t want to anymore. They were aware that the lifestyle is unsustainable in the long term, but were not ready to make the necessary changes in the short term.

**Cathy:**

I kept thinking, “Next week. I’ll do it next week. I’ll just withdraw. I’ll come off it.” Next week never comes and that withdrawal just doesn’t happen.

**Beverley:**

It’s doing my head in. I need to sort it out. I can do it because I’ve done it before. I would be happy not doing [heroin] at all… But even if I just went back to doing it once a month or whatever I’d be happy with that. I’d rather do it not at all, but it’s really getting me mad at the minute. Getting me down I think. I don’t smoke crack. I've never smoked crack since I found out I was pregnant. But yeah, I still do want to use.
As Beverley said, she is mad at herself for using, and yet still wanted to use. Having made several attempts at treatment, the women felt that past treatment failures were the result of trying to get off drugs before they were ready. They and the professionals who worked with them routinely expressed the idea that you needed to “be ready” before you could expect a treatment attempt to be successful.

Kristen:
I don’t think I was ready to come off it then. Cruz I think when you’re on something like that you’ve got to be ready to come off it. I don’t think there’s no point getting forced into come off it when you know yourself you’re not ready. I don’t think at the time I was ready.

Cathy
And, until you start hating it and, you know, despising it, there’s nothing no one can do…the best one in the world…there’s nothing no one can do, you know. You’ve got to be really that sick of it yourself or you don’t get a buzz off it, its such a hatred thing. You think “Why am I even doing that thing?…Why am I doing it?” You know, it’s got to come from you first, definitely…and only then will you say, “Help…I need help…can somebody help?”…and can you receive it, you know, and get somewhere from it.

“Being ready” is not always about reaching the “rock bottom” that most people would think of: no home, no family, and no money. In some ways there are sufficient safety nets in place in the UK to prevent people from hitting rock bottom. Welfare benefits provide weekly cash (though not much) and social housing provides shelter (though of varying degrees of habitability). Family ties, are enduringly strong (if subject to frequent bouts of overstretching). Instead “being ready” is about “hating” and “despising” the drugs and, one can extrapolate, the life the drugs have made one lead. In
previous research interviews I conducted with male drug users in treatment (Weaver, et al. 2009), they expressed a similar sentiment that they had aged-out of drug use. The daily grind of rattling, grafting, and scoring simply became too tiring and unrewarding to continue with. In the same vein, women said that you could not come off for anyone else and expect to succeed.

**Vicky:**

I think I’m frightened of leaving it more than anything, do you know what I mean, but like I say, now I’m pregnant it’s a case that I want to do it, and it’s got to be your decision at the end of the day. You can come off it for everybody in your family, but at the end of the day it’s got to be your decision, I’ve tried that, coming off it for my mum, coming off it for my family, I’ve always gone back into it, but now I’ve made the decision I want to come off it for my baby and me.

**Mary:**

I’ve done so well and whatever, and everyone’s so proud of me. I wouldn’t let myself down though, you know? I mean, in the past, as well, I always started by saying, ‘I’m going to do it, I’m going to do it, I’m going to come off drugs, I’m going to do it for the family.’ Stop! That’s where it went wrong. Because I couldn’t do it for them, I couldn’t even do it for myself so how could I do it for them? But now I have done for myself, and I’ve done it more for the baby this time really, but I’ve done it for myself more.

What is not mentioned in the above quotations is one significant group of people one might come off drugs for; namely the police. In the UK there are several programs in which a convicted person might be given a choice (if it can be called that) between entering prison or entering drug treatment. A Drug Treatment and Testing Order (now sometimes called a Drug Rehabilitation Requirement) is one such prison alternative. Instead of serving a sentence for a relatively minor crime, like property
damage, a convicted person would be mandated into drug treatment, required to submit to frequent urine testing, monitoring by probation and supervision by health and social services teams. Failure to comply with some or all of the elements of the mandated services can result in a prison sentence.\(^{52}\)

Once in prison, one would also need drug treatment as - in theory - prison is a drug-free environment. Prior studies I have assisted with on drugs in prison have shown this not to be the case, and many ex-prisoners claim that drugs are almost easier to get a hold of in prison than on the outside (Penfold, et al. 2005). Regardless, drug treatment in a prison setting could hardly be said to be free of coercion. As almost all of the women in the study (ten of fourteen) had prior experience in prison while they were using drugs. We can assume that some of their failed treatment attempts were through this medium.

What is particularly remarkable is that of the 7 women using crack when they discovered they were pregnant, all but one completely stopped using crack as their first priority. In the majority of the literature on pregnancy and drug use, most of which has been generated in the US, based on studies of US drug users, crack is seen as a particularly pernicious habit, impossible to kick and causing irreparable harm to the woman and her fetus. While we now know that the “Crack Baby” phenomenon is a myth based on bad science and cultural bias (Boyd 1999; Cosden, et al. 1997; Frank, et al. 2001; Hepburn 2004) the idea remains that crack use is an intractable problem. Yet the women in this study were able to end their crack use through sheer force of will.

**Mary:**

I just stopped myself. Instead of going to the dealer and getting like, getting two, I’d think to myself, well instead of buying one of each [one bag of crack and one bag of heroin], because that

\(^{52}\) http://www.gm-probation.org.uk/what-we-do/offender-management.php
was £30, I could buy three bags [of heroin] instead, because the bags [of heroin] were a tenner [£10] each and the crack was £20.

It is worth noting that none of the seven women using crack were using crack solely; that is to say, ending crack use did not mean becoming drug-free. They all had heroin to fall back on. It is also important to recognize that the physical effects of crack use are significantly different than those of heroin use. Crack, simply an adulterated form of cocaine, is a powerful stimulant, but not one that changes the body’s physiology in the same way that heroin does. The withdrawal a body experiences from crack or cocaine is predominantly psychological, whereas the withdrawal from heroin causes a catalogue of painful physical symptoms (Klee 2002). In pregnancy, if a woman who has been using heroin suddenly stops using, there is a risk she will kill her fetus by withdrawing a drug on which the fetus’s body has begun to depend. Not so with crack, where going ‘cold turkey’ will not harm the fetus or the woman as heroin withdrawal will.

The difference between crack and heroin is also played out in the treatment sphere. There is no substitute prescribing for crack, or for any of the other stimulants like amphetamines, to help people wean themselves off the habit. Instead there are a series of behaviorally focused interventions like motivational interviewing, cognitive behavioral therapy and, to manage the cravings, auricular (in-ear) acupuncture.

However, none of the women in the study took advantage of these offerings to kick their crack habits. They just stopped because they “knew” crack was bad for the fetus. “Like I know heroin’s bad, using heroin when you’re pregnant, but it’s not as bad as crack” (Beverley). Crack was seen as an inherently “bad” drug. The women called it, “evil,” a “demon drug,” and “the devil’s drug.” They felt that crack would “take
everything away from you,” and “that’s where all your money goes when you start taking that crack.” Vicky outlines the distinctions many women drew between crack and heroin:

> Because crack cocaine, you can go on for days with it, for hours. Heroin, you can only take so much of it. It knocks you out. But crack cocaine, it’s an upper so you’re there, you’re wanting more. You’re chasing the same buzz that you’ll never get once you’ve had it the first time. But it’s a mental thing in your head that tells you, “you’re going to get it, you’re going to get it.” It just wrecks your life. You’ll sell everything with the crack cocaine. And people think it’s heroin. [That] you’ll sell your soul for heroin. No. You’ll sell your soul for crack cocaine. You know, powder form, rock form, whatever way you want to take it, it’s still the same fucking drug, and nobody will change their mind over it. You know, you get these people who think, because you snort it, “Oh it’s all right to snort it, and go partying, and Champagne Charlie,” and all that but you put it on a pipe and you’re Rockhead. It’s the same drug; it’s just been based up that’s all. It does the same thing; it takes the same things away from you. Heroin you can always smoke. You can only take so much of it and it knocks you out. Then once you come round you want a bit more, but it’s usually hours and hours later. Whereas with crack cocaine you can sit there 24/7 day in day out. I’ve done a two-week trial on it where I literally ended up fitting [having seizures] because I’d smoked that much I couldn’t smoke anymore. I was fitting and my face smashed into the table and that was just being greedy with it. Ounces and ounces of the shit, and it just took grands (thousands of pounds) away from me. So nobody can sit there and tell me that heroin is worse than coke because it isn’t. And nobody can tell me that snorting it is better than piping it, because it isn’t. It’s the same thing. It’s exactly the same thing, it does the same damage, and it takes the same amount of personal things away from you. I’ve gone from being up there, down to rock bottom, to the extreme of where I sold everything out of my house for crack cocaine, and I’d swore I’d never ever let it get to me like that again, and it hasn’t.

The women in this study all engaged, to a greater or lesser degree, with some services when they found they were pregnant. (Were it not for their contact with MSMS,
I would not have been able to meet them in the first place.) Of the 14 women interviewed for the study, three were not using any drugs on top of their methadone when they fell pregnant. Five of the women were using crack in addition to heroin when they discovered they were pregnant. Of the 11 women using street drugs, all but two tried to make changes to their use as a direct result of the pregnancy. One who did not, Emma, was on a stable dose of methadone and only used one bag of heroin and one bag of crack once a week; a situation both she and the midwives felt was acceptable during pregnancy, though not without its emotional pitfalls.

**Emma**

To be honest, I didn’t really reduce, no. Everything more or less stayed. Although I had the incentive to, in reality it’s not always as easy. Although you’ve got all good intentions -- “Right, that’s it, now. Got the baby to think about.”-- it just doesn’t always happen like that, you know. Although [the baby’s] there in you, and then you feel dead guilty [for using] then ten minutes later. It’s a horrible… it’s a real, like, mix of emotions.

The other woman, Cathy, actually began using again, after a period of stability, during her pregnancy. Only after her (healthy) baby was born, did she equate taking heroin while pregnant to directly feeding drugs to a child.

**Cathy**

I didn’t stop the using, granted, it didn’t stop me using. I suppose it was all a bit surreal. It wasn’t like feeding me baby heroin and “Yeah, come and have some of this.” Which is how somebody put it to me once. I thought “God, if I only would think of it like that!” Like, picking her up now and saying “Come and have some heroin.” You just wouldn’t dream of it, you wouldn’t, you know. But, when you’re pregnant, that’s what you’re doing really, but it just doesn’t seem that way! It seems like “I’ll do mine, I’ll be all right…I can cope with the day and get on with it.” you know.
Those who made changes did not all make the same kinds of changes or make them for the same reasons. The main reason women gave for altering their drug use was to protect the health of their babies. Despite the fact that crack and heroin do not cause fetal deformities, women, possibly reacting to popular misconceptions, feared that their babies would be deformed because of their drug use.

**Mary**

My worst fear was, what if something happens to her when she comes out? Like what if she was handicapped or deformed, you know, because of the drugs and the drinking? And every day of the week I was like, “Mum, something’s wrong, something’s wrong.” And there wasn’t. You just have to think it because you don’t know. And there’s a lot of people out there that have done absolutely nothing and their babies come out sometimes deformed and whatever, don’t they, and they do everything by the book, they don’t smoke, they eat right, and it’s such a shame. But I’m really lucky, Abigail, I really am. That did help me a lot, just being pregnant, knowing that I’d got a child inside me, and I’m still taking these drugs and whatever, and what if I have to give birth to this child and it comes out dead or something, so that frightened me really, because I’d never be able to forgive myself, you know, so that did really frighten me. And with being scared so much it stopped me as well, it’s amazing what fear can actually do.

**Shirley**

There was nothing wrong with her when she was born, not a thing. So really that’s a blessing. Because you know, she could have been born, they say they can be born without limbs when you’re on that crack cocaine. Don’t they? Born without an arm or a leg. I couldn’t be that bad though, could I? I did cut down on it. I’m trying to get there. It’s hard, though, some days.
Others felt uncomfortable with the idea of bringing a child into the world with heroin in its system or into a heroin-filled environment. The newborn baby, with its associations with purity and innocence, served to highlight the women’s feelings of their own impurity.

Vicky
Just the thought, it just makes me feel sick. Because I never, ever wanted to bring a child into the world with drugs inside it. But there’s not much I can do about it. Because even if I stopped taking gear, it’d have a methadone habit.

Laura
Because you don't want to bring another life into the world in the mess that you are in. You want to try and change the mess. You just don't want to bring a kid into that. Anyone who is in their right mind doesn’t want to bring their kid into that. It’s wrong, because the kid will end up as messed up as what you were.

All of the women wanted to protect their babies from experiencing withdrawal symptoms at birth. Since, at various points in their lives, the women themselves had been through withdrawal from heroin and also from methadone – which some describe as worse than heroin withdrawal – they understood firsthand how painful the process could be and wanted to spare their babies that pain. As Beverley said, “[I cut down] just for the baby. I can’t cope with being ill and withdrawing, never mind a poor little baby.”

However, not all women chose the same approach to limiting withdrawal in their babies.

One of the more confounding aspects of heroin use in pregnancy is that there is, as yet, no clear method for determining which babies will experience opiate withdrawal
at what severity. There is not, as one would expect, a linear ratio of methadone or heroin dose to withdrawal symptoms. An increase in heroin or methadone use by the mother does not necessarily correlate with an increase in withdrawal symptoms for the baby.

There is conflicting clinical research evidence on the phenomenon, with some researchers asserting that there is a correlation between maternal methadone dose and rate of neonatal abstinence syndrome (Dashe, et al. 2002; Doberczak, et al. 1993; Dryden, et al. 2009), while others have found no such correlation (Brown, et al. 1998; Mack, et al. 1991; McCarthy, et al. 2005). More recently, two meta-analyses of clinical studies from 1966 to 2009 have supported the assertion that there is no correlation between the severity of neonatal abstinence syndrome (NAS) and maternal methadone dose (Cleary, et al. 2010; Thajam, et al. 2010), an observation echoed to me by the experiences of midwives in the delivery suites of Manchester’s three hospitals. Women who were on 60 ml of methadone (a moderately high dose) could have a baby with no withdrawal symptoms, while a woman on 5 ml (a very low dose) could have a baby with severe symptoms. Jansson and Velez (2012) in their review of neonatal abstinence syndrome also point out that the appearance of NAS can be effected by multiple factors including polydrug use, epigenetic factors such as maternal depression which has been shown to affect fetal development, or even genetic factors associated with maternal drug use that do not necessarily indicate infant withdrawal. At the same time, the women themselves do experience withdrawal severity in direct correlation to the doses they are on. One of the midwives from the MSMS is, at this writing, undertaking a study to investigate whether there may be a placental protein involved in mitigating the delivery of opiates to the fetus which might explain the discrepancy.
Perversely, heroin withdrawal is also quicker than methadone withdrawal. One of the benefits of methadone over street heroin is that its effects are long-lasting, allowing a woman to take a single dose to maintain her all day. Heroin withdrawal in a newborn can start within 24 hours after birth and peaks within 48 to 72 hours, whereas methadone withdrawal may not peak until 48 hours to two weeks or more after birth (Hamdan 2012). To limit the length of time their babies will suffer, some of the women chose to use heroin instead of methadone.

**Beverley**

There was nothing wrong with Maisie when she was born, but everybody kept telling me, “Don't take the methadone. If you are going to do anything, have like a bag or two [of heroin] rather than take 50 ml of meth. You’re best on gear.” And it did, it was obviously right because…This is what people kept telling me. So I did, I took 10 ml of meth. I didn’t even really take the methadone. Just maybe a little tiny bit, 10ml, and I think eventually I stopped taking it and just used a bag [of heroin] or two. I was in hospital four days and only because she was so small. That’s why I had to stay in and she sneezed once…But yeah, if she was withdrawing she would have gone into special care. And she can’t talk; all she can do is whinge. So that's why as well. I only found out off people saying you’re better off not having any withdrawals.

**Laura**

A lot of the girls we used to hang around with [gave us advice] because they were drug addicts and have got children. But I’ve never known anyone to have a baby who has been seriously damaged by drugs.

**Mary**

Yes, [my friends] were saying things like “When I had my baby, I was on drugs all the way through, and she was fine, and he was fine.” You know, just things like that. And I was thinking, “No, this can’t be right.” It didn’t feel right, anyway. So I went with myself and I thought, “I’m
not doing it.” So I stopped it myself. I know a lot of people who have had babies, taking drugs as well, and the baby has been fine, but it does something to them mentally, though, as well, I think, the child as they’re growing up, and I think they might be disturbed. I don’t know.

All this uncertainty leaves the women in a state of some confusion. Personal experiences, peer experiences, advice from midwives and social stigma all intersect to give women conflicting messages about how best to protect their children. Given the guilt a woman feels when her baby withdraws, feeling that she is the cause of its pain, one can understand the frustration a woman feels when she has significantly reduced her drug consumption only to have her baby withdraw more than someone who has not made such good progress.

**Gabrielle, MSMS midwife**

So we do talk to women an awful lot more about stability, and why we want stability, rather than reduction. And you know, they may have to go up [in methadone dosage] towards the end of pregnancy, and that’s really hard for them to hear. So a lot of it is around supporting the women to come to terms with that. And we talk a lot about, “You’ve got to be able to listen to your head and not your heart.” And it’s really difficult. So it might take a couple of visits before they can get in their heads about the idea of stability. So we’re trying to do it from like a dual thing, aren’t we? Sort of like supporting the women to get their heads round that, but also supporting the midwives and other health professionals, social workers, to get their heads round that as well.

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53 When I asked women how they got information, I asked specifically about their access to the Internet and whether they saw this as a primary source of information. What I found was a perfect example of the digital divide. Though 57 per cent of households in Great Britain had Internet access in 2006 (Shepard 2007), few women in this study had any access (either at home or through friends) to the Internet (3 of 14) and none had any idea what they would do with the Internet if they could access it. The recent proliferation of “smart” (web-enabled) cell phones may alter this in the future, but at the time (2004-2007), women in this study typically used pre-paid phones, which were overwhelmingly cheap and basic (with texting capabilities but no Internet). As the smartphone technology gets less expensive, perhaps more women will have them, but fancy phones are easily stolen or easily sold when money gets tight. Costly data plans are likely to remain out of reach for women without the credit history, or indeed the consistent address history, required to get a cell phone contract. This population of women is unlikely to be able to rely on a consistent source of web (and thus, knowledge) access.
Gabrielle points out that it is not only the women who struggle with the idea that a woman might need to increase her methadone while pregnant. Just as drug-using women are susceptible to cultural stereotypes about “Motherhood,” health professionals are susceptible to stereotypes about “Druggies.” If a woman feels that “Mothers” should sacrifice for their children, using more methadone during pregnancy is a violation of that ideal. Conversely, if professionals feel that “Druggies” are incapable of self-control, a pregnant “Druggie” on a large dose of methadone confirms the stereotype of a woman unable to control herself.

As expressed by Beverley above, women felt pride when their babies did not end up in the neonatal intensive care unit (NICU) or the Special Care Unit (SCU). Healthy babies were an outward proof that they had done the best for themselves and their children, and were seen as a bulwark against claims of unfitness by Social Services, the first test of your care of your child. To give birth to a baby who was withdrawing badly was seen by the women and by some professionals as a sign that the mother’s habit was out of control. One might be able to hide one’s own suffering, but a crying baby calls you out publicly.

Vicky

[My son] will know that I was a junkie in the past. And God forgive me, I’ll tell him that I took drugs while I was carrying him. I’m not proud of the fact, but you know, thank God, when he was born they didn’t have to give him anything. All he had was the sniffles, which was a bonus anyway, because the minute I saw him it just broke my heart crying. And I thought, “Why have I let this baby suffer?” And like the nurses told me, he didn’t have to have any morphine or anything, all he had was the jitters and the sniffles. And me saying that’s all he had, that was bad
enough! Because you know, he wasn’t brought into this world to have a habit. And I don’t intend him to get a habit when he gets older, or see his mother having a habit.

**Fear of Social Services**

As mentioned above, the other primary reason for engaging with some of the medical services was to avoid scrutiny or punishment by Social Services. For all drug-using women, the threat of child loss looms large. Drug users are subject to an automatic intrusion into their parenting not experienced by non-using parents.

The British are fond of using the expression “post-code lottery” to describe the disparity of public service provision throughout the UK. This means that different areas of the country, and in some cases different areas within the same city, may offer different – though still government-funded – services. Each region of the UK is divided into Strategic Health Authorities (SHA), which are responsible for determining and funding the services most appropriate for their area. For example, in 2010 a cancer drug fund was set up by the UK government to offer patients access to new cancer drugs not typically offered within the NHS. Each SHA was given its own pot of money, set up its own expert medical panel and chose its own list of approved drugs that would be available through the fund. A patient in London would, therefore, potentially have access to a different combination of cancer treatments than a comparable patient in Manchester, simply because they lived within different SHAs.

The post-code lottery comes into play for drug-using mothers most significantly in their interactions with social services. Though the stated policy position in the UK is
that drug misuse does not in itself constitute bad parenting, problematic drug use⁵⁴ is seen to adversely affect parenting and to harm children. Yet the somewhat circular logic that drug use is defined as “problematic” when it causes problems leaves room for interpretation on the part of social workers. As workers explained to me, behavior that would have your children instantly taken away from you in a wealthy suburb would be considered acceptable in a poor one. Counterintuitively, this is because workers in Manchester, one of the poorer cities in the UK, see a greater range of problems, vulnerabilities and triumphs than workers in neighboring Cheshire, a favorite homestead of football players and their families. Workers who are used to seeing unemployment, substandard housing and drug use are less shocked by the living and parenting conditions that these produce than are those who work among white picket fences and well-washed SUVs.

For drug-using mothers, the post-code lottery can work in their favor. Being unfortunate enough to live in highly deprived areas, they may actually benefit from greater sympathy among social workers who are highly experienced in dealing with underprivileged populations. Manchester’s social workers see women’s deprived conditions as hurdles to parenting, rather than barriers, so they are more willing to help women navigate them. As John, a social worker who deals primarily with homeless families, explains below, his experience with highly disadvantaged populations gives him a wider perspective on the families he works with than someone not used to seeing so much deprivation.

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⁵⁴ Problem drug use is defined as “drug use with serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them” ACMD 2003.
John, social worker

Depending on which authority you are in, there’s some, they do have a different threshold, really. For our particular team, you know, we’re on the homeless team, so we’re used to seeing families in chaos, if you like. If it was a social worker coming in from the middle of Cheshire into some of our family homes, they’d probably see it as chaotic and remove the children immediately. But because we’re used to, it’s not like you become immune to it, but you’re looking beyond those current situations. So in our circumstances, you know, just because the house is a bit of a tip (messy), doesn’t warrant the children being removed.

Despite the workers’ higher threshold for chaos and mess, however, all the women in the study either knew someone who had had children taken into care or had had their own older children taken from them. All of the women in this study felt they were at risk of losing their children.

Mary

[The thought of using drugs] frightens me as well, because like, you do see things happen where Social Services get involved. And because they already know that I’ve, you know… I’m on methadone. Therefore, if anything like that happens and I’ve got to go to court and gone to the police station, then obviously if you’ve got a child the police have to notify whoever because you’ve got a baby. Then they could be watching me for the rest of my life.

Zoe

[Social services were] all right actually, but with my daughter [an older child who was taken away from her] I never paid any attention to [the social worker] whatsoever. But, it was different with [my son]. [The social worker] wasn’t bothered, was she? She wasn’t interested. She never came to us. She never wrote to us. She never did anything. All our meetings, I found out about through Gabrielle or through my drug worker. That’s how I found out about our appointments. Once she wrote to us, and that was on the day, we got it the day of our appointment. So she was useless, but
she was helpful in a way, do you know what I mean? We never saw her. She never came to see if he was all right or anything. It was nice, but still, it was on my head that she was taking [my son] from me because [they] did it with my daughter. If you do what they ask you to do, you end up with a baby, but if you don’t and you work against them, they take them away. Which I found out.

Rachel

I mean, when I was pregnant with Callum that’s all I could think about, “They’re going to come and take him away, they’re going to come and take him away.” You know, you just think that, because you’re a drug user, they’re going to come and take your kids off you. That’s what I thought, and they put my mind at rest, they said, that’s not what we’re about, we’re not going to come and take your kid away, unless we really feel we’ve got cause.

Previous experience with social services taught women that compliance was the quickest way to ensure that they kept their children. Though, as Zoe mentions above, compliance is not always easy. Appointments for meetings, evaluations and doctor visits are made by mail, which, given the housing difficulties faced by this population, is a particularly problematic communication tool. A letter is sent informing you of the date and time of your appointment and you are expected to show up. I experienced this first-hand during my own pregnancy in the UK. My pre-natal scans were scheduled without any reference to my own commitments, or, indeed, to my pregnancy. My “twelve-week” scan was firmly scheduled for my sixteenth week of pregnancy, too late to perform the nuchal fold scan that would rule out Down’s syndrome without further invasive testing. I mention this to point out that it is not that drug-using women are singled out for shoddy treatment, but rather that the system is equally indifferent to all women.
Attending appointments is the most obvious display of compliance. Non-attendance equals non-compliance and earns a woman a black mark in evaluations of her fitness to parent. Women are expected to attend appointments with doctors, social workers, drugs workers, probation workers, community and specialist midwives, health visitors and potentially a whole series of other support workers for things from housing and benefits to mental health. Failure to attend appointments with any of these workers can start the chain of investigations into one’s fitness to parent.

**John, social worker**

If the child can’t be parented where it is, you know, we’ve got to think of the child. Can’t really think about the mum, although we do have to look at the holistic picture… We don’t go in and remove a child immediately that we find out a parent is using, you know. We will look at a plan of support put in place for that family, and all avenues will have been exhausted before that child is removed. We don’t just remove just because they’re using. There will have been a number of planning meetings may have taken place, you know, involving the community drug team or community alcohol team, and it would have proven that the parents are just not engaging properly, not following the signposting that their drugs team have given them… and it could be that they just can’t do it, you know, people haven’t got the momentum or whatever it is to get off their bum and go and do it, you know. They just find it too difficult. Some people just can’t do it.

**Juliet, drugs worker**

But I also think one of the things that does worry me a lot is, you know, a lot of the signs that things are slipping is kind of an ability to attend appointments. It’s that kind of drug using now that affects routine.
As Beverley said, “It only takes one person to get a bad impression of you” to start that chain of investigations. Zoe, above, was referred (perhaps reported is a better word) to social services three times when she became pregnant with another child less than a year after giving birth: first by her health visitor, then again by her housing support worker, then again by the midwife on the labor ward when she gave birth. In the last case the hospital midwives refused to discharge Zoe from the labor ward, insisting that Social Services needed to come and check up on her. Zoe was discharged only after one of the MSMS midwives called Social Services and discovered that there was never any intention of opening a case into Zoe’s parenting.

It is worth exploring the power dynamics of a system where women are not given the opportunity to opt out without suffering the consequences. In my own interactions with women, their disappearance from the study was sometimes the first clue to their slide back into heavier drug use, but it may have been nothing more sinister than that they were bored with talking to me and wanted to be left alone. Being left alone by Social Services, though, is not always an option. The women’s interest in parenting their children without interference comes into direct conflict with the state’s interest in protecting children from potential harm. These tensions are particularly pronounced in the subjective and post-code-dependent nature of who receives and who escapes state scrutiny.
Drug Use After Pregnancy

Vicky - March 2006

But as soon as the baby comes, that’s it, I’ve told him, I’m not going to pressurize you, I wouldn’t want you to pressurize me, but when this baby comes there’s going to be no narcotics in this house whatsoever, before the baby gets here, anyway, because the minute I feel, if it’s still happening, the minute I feel I want him to leave, everything goes. He’s agreed with it, and he is prepared to sort it all out, so give him the benefit of the doubt, I said, because the day the baby comes and you’re still taking, you’d better go back to your granddad’s, because it’s not happening, it isn’t happening. I’m no angel, I’m still using, but nowhere near what I was using, I could sit here from 9 o’clock till early hours in the morning smoking at one time, and from when Gabrielle told me the dangers of what drug does what, like the coke, I still took it but nowhere, like I used to go through £200 to £300 a day on it, now if I have it every, well, if I have it twice a week it’s a lot, and it’s only a smoke that I have.

Vicky - July 2006

No, I mean, it’s just because it’s there, if it’s not there it doesn’t bother me, but because it’s there I’m taking it, once my mind is made up and I know I’ve got to go in rehab and do it, it won’t be…for the pleasure anymore, because I need to do it, I need to get myself clean. And not only that, my baby will start looking at things, and seeing things, and understanding things, and I don’t want that. I’d never thought I’d say I’d still be taking it when I had him, but it sounds a sad excuse, the pain that I was in when I first came home, I took the gear just to stop the pain.

Vicky - October 2006

So we both, I intend to do it and so does he. If we’re together when he’s older, I don’t know, you can’t always face the future and see, you know, it’s going to be the same as when we first got together, but you know, he’ll always be his son, and his son will always see his dad, but he’ll never grow up seeing us taking drugs, never, I don’t want that. I’ll do myself in first, because there’s no way my child is going to be brought up seeing a drunkard or a junkie, no, it wasn’t
planned anyway, it was a big shock to me getting pregnant, so I don’t see why he should be
brought up seeing, I’d be a hypocrite to say all that I’m saying now and then five years down the
line I’m still doing it. Because I may as well just say, right, take my son away from me because
I’ve told a load of lies, and nobody’s taking him away from me, nobody.

Vicky - April 2007

It does worry me, though, it does worry me, because it’s hard to survive for me right now, do you
know what I mean, but only because, I put it down to the drug abuse, but like me and him have
had a talk and I don’t want this drug abuse anymore, I really don’t, I brought it back down to zilch
at the minute. Brought it right, right down, but it’s hard to let go of it, it is very, very hard to let go
because that’s all I’ve ever known, and I keep looking at my son every day and I’m thinking, you
don’t need this around you, he doesn’t need it around him, he’s not in the room when I’m doing,
don’t get me wrong, but he doesn’t need it, it’s been in the air, he doesn’t need that, this is his
home, this is his life, he’s got to grow up, so it’s getting there slowly, but it’s just letting that last
thing go.

Pregnancy is a period when many women, drug-using or not, have strong
motivations to make lifestyle changes “for the baby.” But what happens to those changes
once the baby is born? It is clear from Vicky’s quotations above that despite her initial
strong motivations and sense of conviction that she will be able to eliminate her drug use,
over time she is unable to live up to her own ideals.

So are children less of a motivation than fetuses? For my peer group and myself,
our first pregnancy was all-consuming. We were actively pregnant every day. We read
books and took yoga and drank weird “uterine tonics.” We had birth plans and baby
clothes ready well before we’d need them. We were going to breastfeed for twelve
months, and our children would play only with sustainably farmed, ethically sourced
wooden toys, preferably from Denmark. It was only after the babies were born -- as the shiny, plastic, beeping, light-up toys began to overrun the living room and the realities of feeding-on-demand in the dead of winter set in -- that we realized how naïve we had been.

For the women in this study, particularly those with multiple children, it is hard to maintain the fiction that pregnancy alone is enough to drive sustainable lifestyle changes. Nine of the fourteen women in the study had had children prior to their current pregnancies. All nine struggled with controlling their drug use during at least one of those prior pregnancies. All of them were struggling again during their current pregnancies. In two instances, the women had already had children before ever trying hard drugs. Clearly, motherhood is not protective against drug use, a fact that the women themselves readily acknowledge.

Mary

I’ve started to realize a lot of things as well. And I’m just so glad. Like, I didn’t use to look at it like, “I’m so glad to be alive.” And I just used to feel like, “Where’s my next drugs coming from?” And all that. It didn’t really matter to me. But you know, having Samantha now…I mean, some people…I’m sat here saying it changes a lot of things, but it doesn’t to a lot of people. Because some people are not bothered, are they? Some people get pregnant, have the baby, say they can cope. You know? Then they’re still on drugs. Still doing whatever. They’ve not really achieved anything. And then they end up getting the kid taken off them, and they’re back to square one. So with me it’s completely different because none of that has happened, and it won’t happen. [But] …any little thing could trigger you off. Couldn’t it? Every day I look at Samantha and I think, “I don’t have to do that, you know, I just don’t have to.” Well, don’t get me wrong, I’d be a liar if I sat here and said, “Oh, I’ve really got over it now, I’m doing really well.” Which I am doing well. But I do sometimes, you know, I sit down and I sometimes think, “What if I had [heroin] one more time?” Because I’m bound to. I was on it for eleven years.
Laura

Well, I know I’ll always have a problem with drugs. In twenty years’ time I could go back. You never know. I just don’t want that lifestyle anymore. I don’t want to go out pinching, being arrested, my little girl being put with people like my little boy was. It was just that I was messed up. I couldn’t see. I knew it was wrong, but I was just wrapped up in it that much, I just couldn’t get out of it that time. Whereas, now, I don’t want that life. I just don’t want to end up going back because I don’t want that life. I just want it to be different. But, like, I can sit in rooms [where people are] smoking and I still say, “No.” But there’s days where I’m sat in a room and it smells good and I’ll go, “Oh, give me one.” It depends how I feel. And that’s what I don’t want. To be put in that position on a bad day. Someone’s smoking and you say, “Oh go on, just give me a smoke.” Or whatever. I’ve gone back on a bad day. Do you know what I mean? If [my partner] just lapses, he might pull me completely back down, I don’t want that, I don’t want that life anymore.

Laura and Mary express strong motivations to change their lives and yet both are acutely aware of the pull that drugs have for them. Mary, for whom this is her first child, is optimistic that she won’t return to drugs even though she has seen others make the same promise. Laura, having already lost a child to Social Services, knows from experience how difficult it will be to make the changes permanent. Both women feel the danger that one day “something” might happen to draw them back into using again, a sentiment expressed by several of the women in the study. As Mary says, “any little thing could trigger you off.”

At the same time, however, women in the study continually expressed a desire to get away from a life dominated by drug use. Their frequent attempts at drug treatment (six attempts per woman on average among all the study’s informants), even before
pregnancy, are an indication of their continued dissatisfaction with the lives they are leading. So why would a woman who feels her drug use is harmful and who has worked to make changes during pregnancy return to drug use after her child is born?

Although it may be tempting to see relapse as a failure on the part of the woman, her will power or her motivation, there are a few moments when one can see the seeds of relapse being sown. For instance, in the three hospitals in Manchester, nurse-midwives are authorized to prescribe 10 mg of methadone every four hours, up to 60 mg per day, to a woman admitted to the hospital who is not already enrolled in a formal treatment program (South Manchester University Hospitals NHS Trust 2006). In other words, if a drug user was admitted to the hospital and it could not be established by the nurses whether or not the woman was in treatment, the nurses are empowered to provide her with methadone as a precaution against her going through withdrawal. Sadly, though, the MSMS midwives encountered numerous cases where this did not happen. In one case, a woman named Cindy was admitted to the labor ward for monitoring of her pregnancy. She told the staff that she was not in treatment and would need methadone while she was in the hospital. The staff asserted that they could not provide her with methadone if Cindy did not have a drugs worker to prescribe it for her, in direct opposition to the hospital policy. Cindy was left on the ward for three days with no methadone. Because she was “left rattling” (withdrawing), as Kate, the MSMS midwife, put it, Cindy’s only recourse was to try to score street drugs to stop the pain.

The hospital staff was not trying to be deliberately cruel to Cindy. They were trying to be conscientious about giving a controlled narcotic to someone who might abuse it. Unfortunately, by refusing Cindy hospital drugs, they forced her to seek out the logical
alternative, street drugs. In the eyes of the hospital staff, Cindy’s pursuit of street drugs confirmed their stereotypes about drug users who cannot control themselves, even when pregnant, and reinforced the correctness of their decision not to give her methadone. In Cindy’s eyes, she was being punished by the staff for being a user, which fueled her distrust of the professionals intending to help her.

A similar problem that MSMS midwives encountered in the hospitals was the occasional failure to give women enough methadone to sustain them until they could reestablish contact with their pharmacy after hospital discharge. This problem was more acute on weekends, when women were unable to get in contact with a drugs worker or their doctor to help them sort out an alternative prescription. Again, staff were not acting out of cruelty, but out of fear that the drugs would be misused. And again, in the absence of methadone, women opted for the next best thing, street drugs.

Gabrielle, MSMS midwife

The expectation from other professionals, particularly in the midwifery profession, was that if the women are not off drugs, then they should be. And also there was a lot of misconception, I feel, around methadone treatment programs, and drugs-related withdrawal in infants. I think mostly that they had a very negative view of women that were on methadone treatment programs. When in actual fact, it should be sold as a very positive move for that woman. A very positive step for her to be on a methadone treatment program rather than the illicit drugs, but I think midwives still had a very negative view of that. It would almost be a “Oh, and she’s on 50 mils (milliliters) of methadone!” type of thing. “Oh, she’s a methadone user!” You know? That very negative thing. They weren’t really understanding that that’s a huge step for a woman, to get on a methadone treatment program and all that that entails.
Alice, drugs worker

I think, particularly in the maternity wards the main feedback I’ve had is that women feel they’re being… that the nurses have treated them not as nice. Nurses have not been as nice to them.

They’ve often, you know, made women really wait to get the methadone…. We generally have poor communication with hospitals. I mean, often a client will turn up after having not been seen for three weeks, not had a prescription for three weeks, and you’re like, “Where have you been?”

“Oh I’ve been in hospital, didn’t they phone you?”

As the MSMS midwives stressed to me, there would never be a case when the nurses would withhold someone’s diabetes medication or asthma medication, but because of the stigma surrounding drug use (perpetuated, perhaps, by experiences with people like Cindy), women were left to suffer. Each time a woman received care rooted in stigma rather than science, her chances of changing her lifestyle shrank. Misunderstandings about when and how to give medication to a drug-using pregnant woman in hospital were common enough to prompt the MSMS to undertake formalized training of the staff at the three Manchester hospitals in dealing with drug users.

Another possible answer to why women relapse after pregnancy may lie in the focus on changing “for the baby,” meaning the *in utero* fetus. Of necessity, much of the work midwives and other health professionals do with a drug-using woman during pregnancy is centered on preventing harm to her fetus. An unintended consequence of the focus on *in utero* harm is that women may consider the drugs’ effects only insofar as they cause physical harm, such as birth defects. Women may fail to consider other indirect harms of parental drug use, such as unstable living environments or the risk of incarceration, when the goal of reducing drug use is presented as protecting the fetus. In other words, the drugs are seen by women as harmful to the fetus, but not to the child.
**Beverley**

I might have [heroin] for a few days, and then I might go a couple of days and not have it. But I have been using more [heroin] since I’ve had the baby. And I don’t see how it can do her any harm now.

**Emma**

You do think, “Well, [the baby is] out of me now. So whatever I do to myself I’m not hurting the baby.”

**Mary**

[I’m not using heroin] because I’m thinking about baby more, and because it’s coming more to my due date as well. I’m just not bothered [to use heroin]. I don’t want to know. All I’m interested in is the baby. But then after I’ve had the baby, and the baby’s not inside me, will I want to start taking drugs again, or will I be too busy?

Each of the women quoted above is expressing a feeling routinely echoed by ordinary pregnant women that, when the baby is out of their body, life can get back to normal.

**Kate, MSMS midwife**

How many pregnant women do you hear say, “I can’t wait for this baby to be born and then I can have a cigarette, I can’t wait for this baby to be born and I can have a glass of wine” and various other things? Because women do have this perception that this isn’t really their body when they’re pregnant. They can’t do to their bodies as they want. They can’t live the lifestyle that they like.

For these women, getting back to normal can be problematic because there are varieties of normal to choose from: the drug-using normal, the in treatment normal or the
idealized normal of straight, non-using, women. None of the choices are perfect, each brings its own challenges and obstacles, but a return to the drug-using normal is certainly the most readily available, if inherently risky.

**Shit-Life Syndrome**

However, as one of the drugs workers points out, there can be a different slant on women’s return to drug use. While wanting to protect the fetus from harm, the women may not see a similar need to protect themselves.

*Alice, drugs worker*

Our client group does have very low self-worth as a generalization, they’re treated as derogatory by society, looked down upon, so it’s hardly surprising they have low self-worth. And often what they’ve had to do to get drugs, and committing crime, prostitution, or whatever, it’s going to shatter their self-worth and self-esteem, and perhaps they think, well, for the baby I’ve got to make this effort, but once the baby’s out, well, so what if I use, I’m not really worth anything, maybe that’s all I’m worth.

As explored earlier, the drug-using women in this study live in very disadvantaged circumstances and have complicated life histories. They live in the fifth most deprived area in England. Even within Manchester, their neighborhoods have extremely high levels of poverty, unemployment, crime and drug use and extremely low levels of educational attainment and economic growth (Department for Communities and Local Government 2011). The women in this study have survived sexual and physical abuse, imprisonment, and child loss, among other hardships. To return to a quotation from Zoe:
[Heroin] just makes you forget for a bit, doesn’t it? What’s ever happened to you in the past. But it doesn’t make you forget completely, so you’re just out of your head. You don’t remember anything, do you? As soon as you wake up it’s still there, no matter what. You can’t forget anything because it’s still there.

The “it” Zoe is referring to is the years of abuse from her stepfather, the removal of two children from her care, a history of street sex work, her current housing and relationship difficulties, and the struggle of trying to raise two children under the age of two. When she “wakes up” from heroin use, “it” is all still there. When a woman reduces her drug use, she is confronted with a much harsher reality than the “cotton wooled” version she may have been experiencing for the last several years.

**Juliet, drugs worker**

To me it’s very much about understanding why people use substances in the first place. One of the things I do when I go out and do training, when I talk to the people I say, “You’ve got to understand the sort of client group that you work with. An awful lot of them have had what one of my colleagues calls Shit-Life Syndrome.” And it’s that thing about heroin, [it] cotton wools you. You don’t feel any emotional pain. The crack gives you confidence that you’ve never had. Why would suddenly having a baby make all those things better?

**Gabrielle, MSMS midwife**

It’s a bit like the chicken and the egg, isn’t it? What comes first? Have they arrived at this place because they started using illicit drugs, or have they started using illicit drugs because they’re at this place in their life? … They’re using drugs maybe as a crutch or a coping strategy. So if you’re asking them to make changes on drug use, then what will we put in in their place? So, for example, a person that you’ve been to see, she did make good changes. But, you know, it was really uncomfortable for her to be in what she would call “the straight world” because she’s getting loads of negative all the time. That’s not good for yourself. It’s not safe for your self. How
you feel about yourself. So why aren’t we putting things in there that make her feel really positive about herself, so she can stay in what she calls the straight world? The women might put in all of the work and loads of effort, but there’s no services there to support her.

When women are suffering from “Shit-Life Syndrome,” fixing their drug use will not fix the wider problems they face. In theory, the services that converge around a woman when she is pregnant are meant to address some of the issues that make her life difficult, like getting her housing or financial support. But a house, however nice, is not going to provide long-term emotional support. Nor is it going to offer an alternative to the engrossing, albeit monotonous, day-to-day of drug use.

Rachel

It’s not so hard getting off the drugs; it’s staying off them. It’s changing your whole lifestyle, isn’t it? It’s changing your friends, even where you live, possibly. You know, everything. So that’s the thing. It’s changing every day. Finding myself something different to do rather than, you know, rather than take drugs. Do something else.

Vicky

Because to me, I’ve been in a coma for nearly 20-odd years. It’s like I’ve been out of my face. That’s all I know. So to be normal, it frightens me, because I’m not used to the everyday life. How I’ve been used to is waking up, getting my money, going and scoring. Filling that space up, and going shopping, doing that. I do my shopping, but not like a normal person does. I do more or less everything that a normal person does, but there’s a big gap in it where I sit here and smoke my brains away, where people can go out for the day and do whatever for the day, I’ll sit here for the day smoking.
Seeing drug use in pregnancy out of context – as so often happens – ignores all the preexisting factors contributing to shit-life syndrome. The experience of these women undermines the idea that pregnancy “transcends” a woman’s lived experience, or that motherhood places her on an exalted pedestal where she can raise her children above the shit.

Pregnancy, for this population, tends to shine a spotlight on aspects of a woman’s life that had previously gone unaddressed by women and service providers alike. Problems of drug use, housing, finances, childcare, mental health and even relationships are thrown into stark relief. At the very least, she must demonstrate a willingness to embrace the ideology that drug use and mothering are incompatible. Drugs workers, social workers, health workers and others are all on the lookout for signals that she is failing to live up to that ideal. As demonstrated in the previous chapter, all pregnancies invite some measure of public scrutiny. Still, whereas most women are presumed competent to mother their children, drug-using women are presumed incompetent and must work to prove themselves otherwise.

In her study of women receiving state assistance with prenatal care costs in New York City, Bridges describes this type of scrutiny as producing “state visibility… the ability of the state to ascertain knowledge that may be the precursor of, and justification for, more overt action” (Bridges 2010:982). In other words, in accepting state assistance women are also accepting state surveillance, which in turn puts them at risk of (largely punitive) state intervention. Wealthier women, not reliant on the state, avoid the services and therefore the scrutiny, even though the state’s “compelling interest” in the welfare of the child ought, at least theoretically, to remain the same. Though both the rich and the
poor may neglect their children, the poor are more likely to be discovered in their neglect by the host of state actors demanding entry into their homes and lives. Yet the markers of neglect are based on the material goods the rich can provide almost unconsciously: food, clothing, shelter and education. Love, which is unmeasurable in its application, but immeasurable in its importance, gets discounted.

Drug use, in and of itself, does not alter the love a woman may have for her child. Instead, it alters the material and social conditions under which she mothers, which has an impact on her ability to provide for her child in both tangible and intangible ways. In the following chapter we will explore how women navigated the tensions between drug use and mothering to satisfy the needs of the state, of the child and of themselves.
4

Trial and Error and a Lot of Heartache

“And we are trying. Because consistency is the key, totally. You know? You’ve got to stay consistent. Babies, children, need routine. They need to know, you know, when their dinner’s coming, when it’s bedtime, you know? They need to feel secure. And I didn’t. I was too stupid. Too, maybe, young in my head myself to even know that. But, you know, I do know that now. And everything I’ve learned hasn’t been from my big massive family. It’s been through trial and error, and a lot of heartache.”

- Gina (31 year old mother of 4)

Perfectly wonderful families can produce a total screw-up, and totally screwed-up families can produce wonders. Though parenting undoubtedly plays a role, as we saw in Chapter 2, there are a multitude of factors that influence an upbringing, not all of them within the parents’ control. The aim here is to understand how drug-using mothers attempt to account for some of these factors. How do they juggle drug use and motherhood? How do they navigate the labyrinth of services? How do their own families influence their ability, or inability, to care for their children? And where does child-loss fit within the punitive versus harm-reductionist spectrum of interventions?

Mothering encompasses a range of skills, expectations and challenges that are nowhere else so wholly intertwined. In much of the Western world, women do the work of mothering almost entirely alone, but there are legions of onlookers waiting to criticize the slightest misstep. News outlets devote hundreds of column inches a year to opining on the best and worst ways to rear children. Be a Tiger Mother! Don’t be a Helicopter
Parent! Be French! Don’t be a Narc\textsuperscript{55} Mom! The one message that comes through all the admonitions is that everyone else is probably doing it better than you are.

**Bad Mothers**

In the UK in late 2005/early 2006 there was a media frenzy over the alleged drug habits of supermodel Kate Moss. She was accused of being a crack user and was threatened with a social services investigation into her fitness to parent her then-two-year-old daughter. The story was hotly debated in the press and beyond, and offered an opportunity to ask women in this study what they thought of the widely voiced assumption that a drug user could not be a good mother. While a few said that there were no barriers to drug users being good parents, others were quick to point out that though they felt themselves to be good mothers, they had seen examples of bad parenting by other users.

**Zoe and Thomas (Zoe’s Partner)**

*Zoe* - Just because they take drugs, it’s like saying a drinker can’t be a good dad or a good mum, do you know what I mean? Why can’t anyone be a good parent? People with money aren’t good parents. They don’t see their kids. Do they?

*Thomas* - Boarding school. When something goes wrong it’s someone else’s fault, they’re never there. These people who are filthy rich and own their own business, they’re always thinking of business and profit.

*Zoe* - They don’t see their kids. They’ve always got a nanny.

\textsuperscript{55} A Narc Mom is one who informs other parents of the indiscretions of her children’s friends. The term comes from the narcotics division police officers who are sent undercover (particularly in schools, à la 21 Jump Street) to root out drug dealing/selling.
Gina

Well, I was a drug user and I tried to be the best mum as I could be in the state I was. But, saying that, I’ve seen some really shoddy mothers and drug-using mothers. I was using drugs and I had my own children. If I used to go round to another drug user’s house who also had children I had to take food with me for their children and I’d end up looking after their children because they were shit mothers.

Vicky

There are some drug users that haven’t been good parents where they’ve ended up being that much off their face, the kid’s been left in the pram screaming its head off. A couple that I know that got that far off their face they left the baby outside in the pram and it was a neighbor that found the baby at 12 o’clock at night.

Though Zoe and Thomas see a bad parent as anyone who isn’t paying sufficient attention to their children, Gina and Vicky’s descriptions closely resemble those of the Smackheads from Chapter 2. Excessive or uncontrolled drug use is seen to pave the way for indecent or inhuman behavior. Although every woman was able to give one horror story example of bad parenting, I suspect the stories were less a matter of prevalence than precedence. The bad mothers in these scenarios serve as cautionary tales to warn women of the dangers of letting things get out of control. The bad mother is universal and inescapable. Whether she is the mom of the naughty kid next door or just a convenient label used to encourage conformity, the bad mother is ever-present, and ever-other. No woman thinks she is a bad mother, but every woman has stories of bad mothers. Whether it is feeding a child soda at 8 AM, or not feeding it soda ever, the bad mother does all the things you, a good mother, would never do. Many of the women contrasted their behavior
to that of bad mothers when describing how they were able to juggle drug use and mothering. For this population, the cardinal example of bad mothering was allowing your child to witness your drug-taking. They are referring, in particular, to children seeing the act of ingesting drugs, either smoking or injecting, rather than simply being around a mother who is “on” drugs.

**Mary**

I had a friend -- it’s not just one friend, it’s happened a few times as well -- where the baby has gone and got the foil out of the kitchen and said, “Mummy’s medicine.” And gives the foil to their mum. Because the mums call it to the kids “Mummy’s medicine. Let Mummy have her medicine.” Like they’ll be there having a smoke, and the kids might be crying, and they’ll be saying to the kids, “No, Mummy’s poorly. Let Mummy have her medicine. Then she can see to you.” So the kids have seen their mum with this foil, and all that kid is thinking is “This is Mummy’s medicine.” So every time that kid sees foil they will know that that foil is Mummy’s medicine.

**Cathy**

The way that she’s done drugs in front of him, actually in front of him. She’s not done it, sort of, behind closed doors or under cover. She’s done it there, in the face. He’s seen a lot of things he shouldn’t have seen, you know. She started treating him as an adult, when he’s not, you know … He’s been a kid but he’s been forced to grow up, if you like…before his time, you know. [He’s seen] his mother injecting, smoking a pipe, shoplifting, being nicked [arrested], arguing with a runner, drug dealing at the house…pretty much everything…men coming and going from the house, you know. He’s seen a lot of it over the years and now I feel sorry for him.

Women in this and other studies (Advisory Council on the Misuse of Drugs 2003; Rhodes, et al. 2010; Richter and Bammer 2000) see keeping drug use hidden from
children as a means of protecting the children from harm. Yet, unlike the harms from prenatal drug use, which many women in this study could articulate (even if their fears are occasionally overblown or unjustified), the harms from witnessing use were rarely specified. Instead, women often said it simply wasn’t “nice” for children to see drug use. Like other acts of private pleasure, drug use is seen as inappropriate for children to witness. In this situation, “niceness” can be understood as related to control. Women who cannot sufficiently control their use/pleasure by keeping it away from their children risk drifting into the realm of Smackheads.

That women drew a line between being on drugs in front of their children and actually injecting or smoking drugs in front of their children says a great deal about how they viewed their drug use. Unlike the horror stories above, of parents who neglected their children because they were “off their heads,” these women felt able to use drugs and still care for their children. Because many of the women viewed their use as almost medicinal – women spoke often of needing drugs to feel normal, not high – and consumed drugs within controlled limits, they could claim the moral high ground over those who used with abandon. As discussed in Chapter 1, there is a perceived difference between those who enjoy their use versus those who need to use. Women felt able to parent so long as they stayed within the realm of need. Nonetheless, it is also possible that women spoke in these terms in order to meet the expectations of service providers, specifically, social workers. By adopting the language of illness to describe their drug use, women may have been attempting to short-circuit a primary justification for removing their children. A mother ruthlessly seeking her own enjoyment at the expense

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56 A stark example of a potential harm was outlined in Richer and Bammer’s (2000) qualitative study of 22 heroin-using mothers, four of whom said that their children had witnessed a drug overdose.
of her children is an easy target, a Smackhead. A sick woman trying to control her addiction while still trying to do her best for her children is deserving of protection.

**Protecting Children**

Women used several strategies to protect their children from harms associated with drug use and to avoid being labeled as (or becoming) “bad mothers.” One such strategy was to ensure that the children’s needs were provided for first. Not letting the kids “go without” was a common strategy for limiting potential harms of deprivation, like a lack of food or shoes or school supplies. Drugs were purchased only after all the other money had been set aside or used for necessities. This was particularly true for women like Emma, who saw their use as a treat, only to be indulged in occasionally.

**Emma**

I’ll go to ASDA [a store like a Wal-Mart] and I’ll put, say, £100 on a shopping card. And then I’ll go to school with the kids. Then I’ll come back here and I’ll do what I’m doing. And then I go to ASDA [to shop]. But I make sure I always put at least £100 on something, so I know that, say- - which I don’t- but just say I did think, “Oh, I’ll spend a bit more” [on gear]. I know I’ve got my shopping money so the kids have always got. That’s before I even start.

Providing for children was also a means of ensuring that children looked well-dressed in the eyes of others. If the children looked good, the extrapolation would be that they were also well–looked-after, short-circuiting any suspicions on the part of the authorities. Clean, well-dressed children were an outward sign of good mothering. As mentioned in Chapter 2, poorly dressed, dirty children were neglected children. Rachel notes that providing for her children was, apart from an outward show of good mothering,
also perhaps a means of trying to compensate for being a drug user, using material goods as tacit apology.

Rachel

I think because we’re, because of the drug use, we try and make up for that. I’m always buying them clothes, and you know, things like that. I mean, you could say I’m trying to make myself feel better. But maybe it is because of that drug thing, you know, that I try and make up for it in other ways.

Setting money aside not only ensured that children’s material needs were met, but was also a way to assert some control over their drug use. By allowing themselves access to only a certain amount of cash, women were, in effect, placing a dosage limit on their drugs. When they spoke of their times as chaotic users, they would often refer to/mention the amount of money they spent per day on their habit. Some told me of spending up to £500 or £1000 in a day on drugs when they were “at their worst.” But a £500-a-day habit requires £500+ of illicit work and an increased risk of being arrested and thus losing your children. By limiting their drug use to the small amount of cash left over from their benefit checks, they were signaling their commitment to living in the “straight world.”

Nonetheless, all of the women felt that, despite their best efforts, previous periods of heavy drug use did have an impact on their children. Women with older children were particularly insightful about how their strategies to limit harm were, in other ways,

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57 The British tabloid press loves to scream about “druggies” using their government benefits to buy drugs, thereby classing them as the undeserving poor. But the women in this study are not using drugs because of the benefits. They are budgeting their household expenses to allow for a small amount of drug use, as well as food and clothing, all of which would still need to be funded with or without benefits.
inadequate to combat the more subtle harms that could be caused by a chaotic drug-using lifestyle.

**Emma**

They’ve always lived with me, like apart from my spells in prison when they’ve been with my family, but I had, well, I say, a good run, I wasn’t in prison for about a year, and I was going to schools normal, and just grafting in the daytime when they were in school, and they were always at school, and always looked after, but I suppose my time, if they ever suffered, it was for my time, me being out of the room because I was busy smoking drugs. They never suffered as in, like means, or not going to school, or material things, but when I think back now, they probably would have said, “Right, I don’t want those shoes, Mum, just a few hours of your time, do you know?” I mean, that sort of, and that’s where they did suffer, because I was too busy with other things.

For Emma, drug use and the time required to maintain a large habit, took time away from her children, in much the same way a woman’s work outside the home would do. Yet Emma and others I spoke with felt guiltier for time spent living with their children but not giving them undivided attention, than they felt for times spent in prison. This raises an interesting question. How can it feel worse to give children less than your full attention while living with them, than it does to be away from your children completely? It is possible that because the enforced separation of prison renders them incapable of meeting the expectations of mothering, they are able to put that aspect of their lives on conceptual hold. It is only when they are out of prison and they return to the role of full-time mother that they once again attempt to live up to those expectations. In prison they may still experience feelings of guilt or depression at being away from their children, but the day-
to-day work of mothering is, of necessity, being done by someone else. They are, in
essence, absolved from mothering expectations during their times in prison. There are
echoes of this in the work of several other researchers who have noted that when drug-
using mothers lose custody of their children, even when there is still a chance of getting
them back, they sometimes fare far worse in their attempts to curtail drug taking and to
stabilize their lives (Colten 1980; Kearney, et al. 1994; Murphy and Rosenbaum 1999;

In their study of 68 cocaine-using women in the US, Kearney and colleagues noted that
the women’s identity as a mother was strongly connected to their sense of their capability
as mothers:

Custody loss and its properties – voluntary vs. involuntary, and short-term vs. long-term – in turn
affected a woman’s identity as a mother. Those who voluntarily found a better place for their
children were sorrowful but retained relatively intact self-images as mothers. When children were
forcibly removed, women harbored anger, fatalism, guilt and images of failure as mothers.

Women who believed in their ability and integrity as mothers were more likely to attempt to pull
away from drugs in order to regain custody, whereas those who saw this central social role as
shattered beyond repair were less likely to make this effort.

(Kearney, et al. 1994:359)

Women in prison straddle these conceptualizations of self. They are forcibly
removed from their children and they cannot regain custody while they themselves are in
custody. Yet the maternal role has only been suspended, not necessarily shattered, so they
can repair the damage when they leave prison. As will be explored more fully later,
motherhood is a fluid state for the women in this study. A woman might have limited or
sporadic opportunities to mother her child over the course of several years, during which
time her concept of herself as their mother may undergo a series of shifts. For Emma, being in prison was a period of non-mothering, which was excusable given her enforced absence. When she was home with her children again, periods of self-inflicted non-mothering through drug use were seen to be inexcusable.

Similar to non-drug-using women separating their work and home lives, drug-using women sought to separate their lives as drug users from their attempts to live as “normal” mothers.

**Gina**

I know I wasn’t the greatest mum but if you saw pictures of me, you wouldn’t have known that. I always was complimented on the way the girls looked in that book. That’s easy to say but I wasn’t doing the important part of being a parent.

**Laura**

He never seen me use drugs but he seen the change when I was getting arrested and he had no stability. “Is my mum going to come home tonight?” “Is my mum going to be there to pick me up from school?” Or whatever. He used to say he didn’t like people coming round. When you’re on drugs, life just goes in the opposite way, no matter how much you want it. No matter how much you want to do the best for your child, if you’re on drugs you can’t. The drugs have just got such a grip, such power over you.

**Debbie**

Even though I was using all those years, you know…they were always clean, fed, watered. And we had stories every night, and they were in bed for seven, and went to school. So even though I had some shit going on, I kept that mother bit normal. Or as normal as I could, even though I’d know that, you know, it’s not a brilliant life. And they did see things they shouldn’t have seen, and that. I can remember [my son] coming down one morning and I was crying, and he was like, “Oh,
I’ll look after you, Mummy.” And he was three years old. And I’m like, “No. I shouldn’t have done that to him. He shouldn’t have seen me that upset.”

Laura and Debbie both implied that their drug use forced their children to grow up too fast by, in effect, reversing the caring roles of mother and child. Other women I spoke with during the study would talk about how their children were very protective of them and, in particular, wanted to share a bed with their mothers at night. The women in this study (and the midwives, too, when we discussed it) said they suspected children did this to reassure themselves that their mothers were home, alone and sober. It is possible that this is a strategy adopted by many children of drug using parents as Backett-Milburn, et al. (2008) describe a similar phenomenon among the children they studied. This particular aspect of the effect of drugs on their children is made more poignant when we consider that several women described this form of role reversal in their own childhoods. Debbie cared for her siblings to compensate for her mother’s alcoholism; Beverley and Rachel did the same when their mothers “went off the rails” after their fathers were out of the picture. Whereas the some of the children in Backett-Milburn, et al.’s study felt the role reversal partially gave them a sense of accomplishment and maturity (2008:467) the women in this study felt they had missed out on some vital part of their childhoods by being the adult of the family before they were ready.

The desire to protect children from drug use serves as another indicator that women in this study were not pleased with or proud of their status as drug users (remember, also, each woman’s multiple attempts to get off drugs). The “subculture” of drug-using mothers is not a cohesive or supportive one that women feel loyalty toward in the same way one might feel loyalty toward a musical or artistic subculture. Women want
their children neither to see drug use nor to someday join the drug-using culture. Women in this study were very concerned that their children not live the same life their mothers were living. The mothers saw their lives as damaged and did not want their children to suffer as they had.

**Polly**

I’ll just tell her, you know, “It’s not good for you. It’s not going to get you anywhere in life apart from hold you back, slow you down. Become a slave to it. Learn from your mother and your dad.” Do you know what I mean? “Because we both smoke it and look at us. We haven’t got anything to show for it, apart from you. So you aren’t going to follow the same as us. You do as you’re told, not as you see.”

**Kristen**

If I thought my kids were going to get into drugs or into drink, I’d drag them right away from it, mate! Honest to God, I’d be on their arse 24 hours a day. I’d take them to school, I’d pick them up, I would. Even at 16, I’d be checking up, I’d be phoning them, “Who are you with?” I would. Even at 16, 18, I don’t care! They are my kids. I don’t want them to make the same mistakes I made! Do you know what I mean? I know what it’s done to my life. I don’t want it done to their lives!

Apart from Kristen, who has a concrete plan for preventing her children’s drug use, others expressed the sense that they had little influence over their children’s futures, including whether or not the children got into drug use.

**Zoe**

Whatever he wants. Leave it up to him. It’s nothing to do with us. Well, it has, but it depends. If he wants it let him go for it. I’m not going to plan anything out for him. We’ll make sure he goes to school, and what have you, and gets his education, but after that, it’s up to him what he wants to do. Whether he goes to college, or gets a job, or whatever, it’s down to him.
Yes, as he’s getting older I’ll let him know what’s right and what’s wrong. I’m not going to tell him what to do, or what not to do, I’ll just advise him the best way I can, and hopefully, touch wood, he’ll take it on board.

I suspect there are two factors at work in women’s assertions that the trajectories of their children’s lives are, as Zoe says, “nothing to do with us.” The first is how they themselves were parented and the second is how drug-using mothers, in particular, experience motherhood. When these women were growing up they were not always parented very effectively. As discussed in Chapter 2, “brilliant childhoods” were often revealed to have been problematic in a variety of ways (though, as Zoe’s partner Thomas was fond of saying about his imitative parenting choices, “It never did me no harm”). Yet women in this study, even Zoe and Vicky, who were abused as children, overwhelmingly blamed themselves for their poor choices in life. When asked about their early lives, they stressed that they “knew their own minds” and “no one could have stopped” them from living the lives they did. Women framed the experience of not having been “stopped” as the impossibility of anyone stopping another’s bad choices. Perhaps, because they are unable to envision a role their families could have played in guiding them differently, they are equally unable to envision this role for themselves in their own children’s lives. Moreover, the experience of the women that one could not stop using drugs for someone else, as discussed in Chapter 2, may inform their view that the will of the individual is impervious to outside forces. Likewise, in a US-based comparison of mothering ideologies in 170 heroin-using women versus a matched cohort of 173 non-using women,
Colten (1980) found that the heroin users reported similarly fatalistic feelings about influencing children. The authors reported that women in their study thought that outside forces or “the street had the greatest influence over how children [turned] out.” The authors went on to say that they suspect this attitude reflects some of the women’s regrets about their own lives: “if their parents had had greater control, the ‘street’ might not have led them to heroin” (Colten 1980:10).

Another force at work in women’s sense of control over their offspring is the peculiar relationship drug-using women have with their children beginning from the moment they know they are pregnant. As discussed in the previous chapters, any pregnant drug-using woman in Manchester is either engaged with services or engaged with avoiding services. In both instances her goal is the same, to keep custody of her baby. This is a strange position for a woman to be in. Most women assume that if they get pregnant they will be allowed to mother their children. Indeed, most women probably never have occasion to contemplate any other outcome. But drug-using women can never make that assumption. The omnipresence of child loss has been well documented in other studies of drug-using women, even in the comparatively less punitive policy environment of the UK (Powis, et al. 2000; Street, et al. 2004; Taylor 1993). Despite the efforts made by Social Services and others to reassure women that they are not automatically going to take their children away, the fact that the women’s parenting is continually being evaluated necessarily encompasses the possibility that they will be found wanting. They are “lucky,” as Emma says, if they have all their children with them.

Moreover, there are very specific guidelines, set by the services monitoring women’s parenting, for what the responsibilities of mothering are: food, clothing, shelter,
cleanliness, doctors’ visits and school attendance. Because the women in this study know that these are their benchmarks for success, much of their focus is on meeting these benchmarks, which, given their financial and social circumstances, is no small feat. In such a climate of fear and uncertainty is it any wonder that women are not planning long-term strategies for their children? If your child could be taken from you at any point from birth through age 16, your emphasis shifts to the decidedly short-term. So, although women express a desire to “be there” for their children, in practice they may interpret “being there” through the lens of social services expectations, which stress the operational characteristics of mothering over the emotional. Johnston and Swanson (2006) describe a similar restructuring of mothering expectations done by women who are part-time workers, full-time workers and stay-at-home mothers. In their study of 95 predominantly affluent mothers, each subgroup, while still outwardly subscribing to an ideology of intensive mothering, modified its interpretations of that ideology to reflect and reinforce its work decisions. Though all women promoted the idea that a good mother be “there” for her children, stay-at-home mothers interpreted “there” as physical availability, while part- and full-time working mothers interpreted this as emotional and psychological availability (Johnston and Swanson 2006:517).

Thus, women in this study are triply challenged in their attempts to assert control over their children and claim ownership over their role as mothers. Their own life experiences have given them the sense that parents ultimately cannot influence their children; they are unsure whether they will be allowed to mother their children or for how long, and they are given little scope to define success in mothering for themselves in a way that will be validated by the outside world.
That is not to say that women had no strategies for keeping their children off drugs. Most commonly, women hoped that telling their children about their pasts would prevent them from trying drugs. The implication that drug use made their lives worse underscores again the sense that the women themselves do not want to be part of the drug-using world forever.

Rachel

But at the end of the day it doesn’t matter how much you tell them something is wrong, you know. If they’re going to do it, they’re going to do it. So all I can do is try my best not to let them put themselves in that situation, and if I have to, I’d tell them my experiences, and hopefully that will put them off. I don’t know. Hopefully that will put them off.

Women were also motivated to tell their children about their pasts in order to prevent others from using that information against their children. As mentioned earlier, drug use and criminality were fairly common in the areas where these women lived. It was not implausible that a friend or neighbor would know about a mother’s past, as they were likely to have been a part of it. Even so, the prevalence of criminality in their neighborhoods and social networks did little to mitigate the stigma women felt about their own involvement. Apart from child loss, the fear that someone would use their pasts against their children was women’s most commonly voiced concern.

Mary

Like Samantha could meet someone as she gets older, and, “Oh I know your mum, she used to go around with such a body.” And you know, and [Samantha] doesn’t know anything about it. “Oh, she used to be on drugs.” And, so I’m going to have to tell her, aren’t I? “She was in prison with my auntie.” That kind of thing. Because it happens. It does happen. Kids walking down the street,
you know, young kids, they might not really know anything, “Your mum’s a smackhead. Your mum’s a prostitute.” And it’s not nice for them, it’s wrong.

Cathy
I’m dreading it, in a way, Abigail. I know in my past, you know, they may say, “Your mum was doing this. Your mum was doing that.” I’m not quite sure me-self how I’m going to deal with that one, you know. I don’t want to lie and deny and all that, but I also don’t want her thinking bad of me, you know. Or hearing it from other people, “Your mum was a smack head.”

Kristen
They know about my past, I’ve told them. I’d rather that than when they get older. Kids are nasty out there, you know what I mean? I’d rather tell them instead of, “Your mum is this. Your mum used to do that.” You know? So, when someone comes up to her and says “Your mum used to drink,” she can say she knows about the drinking, you know. So when someone comes up to her and says, “Your mum used to do this and your mum did that,” she can say, “I know already.”

Women hoped to protect their children from some of the stigma they had faced over the years by addressing it head-on. If their children already know “the worst,” they cannot be shocked or upset by others’ attempts to shame them. But it is significant that all of the women referred to people talking about how they “used to be.” Drug use does not feature in women’s present vision of themselves as good mothers.

Women faced a range of complexities in trying to juggle their responsibilities as mothers and the demands of an illicit drug habit. Drug use appears to impose its own discipline and organization, while at the same time imposing its own chaos. The rhythm of funding and scoring is undercut by the inherent uncertainty and risk that accompany all drug transactions/interactions. While all the women tried to limit the harms to their
children, Gina gives a particularly eloquent description of the difficulties faced by drug-using mothers:

You need to stabilize. That’s hard really, because you’d need to be really organized and it’s hard because drug dealers—it’s not like a shop you can go to. You can be running around all day looking for drugs. So it’s difficult to be a good mum while you’re using. If you’re on methadone, that is a totally different thing because it stabilizes your lifestyle totally. But the running around … because it’s all about you when you’re taking drugs. You need your fix. You need to get hold of the drug dealers. You need to get hold of money so you’re taking your kids to shops to shoplift … You might be a good mum one day when things are going quite easy for you but then you’re a crap mum the next day because you can’t find a drug dealer, you haven’t got the money.

Gina’s distinction between the days she is a good mom and the days she is a “crap” mom comes down to days spent focused on herself versus those spent focused on her children. Leaving aside for the moment the inadvisability of taking your child shoplifting, the days when Gina is a “crap” mom are those when she is “running around.” As discussed in Chapter 1, modern expectations of motherhood place all mothers at the exclusive service of their children. The dominant ideology of “intensive mothering” not only places the child at the center of the family but even assumes that a child guides the process of childrearing (Banwell and Bammer 2006; Hays 1996). When a woman finds herself unable to live up to those expectations, whether because of drug use, work commitments, or even an innate aversion to playing with Barbies, she feels herself to be a bad mother.

**Good Mothers**

Women were aware of what they were aiming for when they attempted to stabilize or hide their use, or set money aside: being a good mother. Though more
forthcoming about “bad mothers,” women were able to articulate what a good mother should be to her children. She should be loving and stable, and most frequently, a good mother was “there” for her children “100 percent.” This portrait of motherhood echoes that of the Intensive Mothering Ideology outlined by Hays as the expectation of “self-sacrifice, a child-centered mom-identity, omnipresent accessibility, and mothers as the primary source of education, guidance and emotional sustenance” (Johnston and Swanson 2007:454). There is an expectation that motherhood should be “enough” for women, that the kids should be “enough,” and that women should be able to devote themselves to motherhood full-time (Johnston and Swanson 2007; Lupton 2000; Murphy and Rosenbaum 1999).

**Shirley**

It scares you as well. The baby is first for everything. You can’t put yourself first anymore. I thought it was scary anyhow when I had her, because I had a week of thinking, “God, that’s it now. I can’t just get off on my own. Do what you’ve got to do. You’ve got a baby there. And it’s there for life. It’s there. You can’t just get off. You’ve got that baby to put first and take everywhere with you.” That’s what I used to think. I used to think, “flippin’ heck!” It scared me. Because I thought, “God, what I have done, have I done the right thing?” You’ve got to be there for them all the time.

**Debbie**

I’ve actually got three children. I’m a mum, you know. Because for years I’ve not known where I fit in, and who I am. If that makes sense. I just wanted to find my slot somewhere, and this is it. So I realized that, actually, I’m a mum, and that’s all I need. I don’t need anybody else. I get the love I want off the kids. So yes, [my new daughter] has been brilliant for me because she has kept me clean.
In the quotation above, Debbie is clearly excited to have found her place in life (despite the fact that her two older children apparently did not occasion this realization). Sadly, despite the confidence she shows, “being a mum” was not “enough.” A few months after our interview, Debbie stopped engaging with services, lost her new baby into foster care, ended up back in jail and was not heard from again until she turned up in a neighboring town in the company of a new boyfriend two years later. Though Debbie’s example is extreme, it has been argued that the above expectations of good mothering are almost guaranteed to produce failure (Douglas and Michaels 2004; Johnston and Swanson 2006). Social expectations assume that all women mother from positions of privilege (Hays 1996). Just as the prenatal care guidelines set out in the early 1900’s discussed in Chapter 1 assumed that all women could stop all unnecessary work in the interests of their fetus’s health, the expectation that mothering should be “enough” relies on the fiction that the presence of a child will compensate for the absence of wealth, security, stability and aspiration. When Debbie says “I’m a mum, that’s all I need,” she is buying into the notion that an acceptance of her identity as a mother, to the exclusion of other identities (i.e., drug user, daughter, worker, woman, etc.), will clear away the considerable difficulties in the rest of her life.

Women did not limit the application of these (unrealistic?) standards to themselves. For the women in this study, the behavior of a good mother was sometimes portrayed as the opposite of how their mothers behaved toward them, specifically, in ways that indicate their mothers were not “there” for them “100 percent.”

Mary

She looked after me when I was growing up, she loves us, but I don’t think I got as much love as I should have done. I’d have to say she tried her best, but she could have tried better. I’m not going
to have a lot of boyfriends, and I’m not going to let my child see me with loads of men and things like that, so definitely not. I’m going to be there to love him all the time obviously. And say, if I had a boyfriend, and my child didn’t like this man, then my child’s coming first.

**Laura**

She doesn’t let her kid get hurt and loves him and spends time with him, reads stories with him and puts him to bed, and still at the age of 8, Callum wouldn’t go to sleep unless he sat on my knee and played with my hair. And just listening to them when they’re upset or when they’ve done something wrong, tell them it’s wrong but don’t hurt them, don’t shout at them. Protect them and try and bring them up the best you can.

Mary says that she did not get enough love from her mother and contrasts that with her own plan to “be there to love [her child] all the time.” Laura specifically mentions not letting her kid get hurt, which, given her history of sexual abuse at the hands of her mother’s boyfriends, is particularly telling. Both women are using their dissatisfaction with the way they were parented to construct a new mothering identity that seeks to remedy some of the harms that were done to them.

At first glance the desire to “be there” for their children all the time would seem to counter the idea outlined earlier that women feel they have no influence over their children. However, on closer examination we can see that the difference is between the nebulous ideal of a “good mother” and the attempt to articulate a specific parenting strategy. Being a good mother is to “love your child all the time” and “bring them up the best you can.” Whereas advising your children to take a particular pathway in life is leaving decisions about their future “down to them” and “hopefully…they’ll take it on board.”
As has been discussed in several other studies (Boyd 1999; Kearney, et al. 1994; Murphy and Rosenbaum 1999; Taylor 1993), drug-using mothers imbibe the same cultural proscriptions and prescriptions about mothering as women in the “straight” population. They know that mothers are “meant” to be selfless, inexhaustible givers. The contrast between the maternal ideal and the drug user archetype – the embodiment of selfish, exhausting taker – is a contradiction difficult to reconcile. Women’s embrace of the smackhead/heroin user dichotomy underlines their awareness of these archetypes.

They may be even more acutely aware of how short they fall from the ideal of motherhood because of how debased the identity of the drug user (and particularly the smackhead) is, not only in the eyes of the straight world, but in their own eyes as well. Although conforming to the ideal of the stay-at-home mom, drug-using women deviate from traditional gender roles in being, overwhelmingly, single parents. It is understood that the “investment of quality time” in their children by less than ideal mothers is not valued as highly as that of the stereotypical (mythical?) mom (Banwell and Bammer 2006:510). Additionally, when women say that they are “there for their children one hundred percent,” they are also accepting the fact that the men in their lives rarely contribute even twenty percent to the care and feeding of their children. They know that when things go wrong, they will be given one hundred percent of the blame.

**Child Loss**

For the women in this study, the fear of falling short is amplified by the continual risk of losing the right to claim the motherhood identity at all. However, like much else regarding this population of women, child loss is not as straightforward as it seems. A
child can be “lost” to social services, meaning it was taken into temporary foster care from which the mother may have a chance of getting it back, or “lost” permanently into foster care and subsequent adoption. Custody of the child may be given by social services to a family member, most often a grandmother. Or, the woman may make an informal arrangement with a family member or the child’s father to take over care of the child, without involving social services at all. Some women even talk about voluntarily putting their children into foster care because they feel that they cannot look after them.

As mentioned earlier, half of the women in the study had experienced some form of child loss. Of the fourteen women in the study, seven had all of their children still living with them. Five of those seven had only one child. The other seven had between two and five children, at least one of whom was no longer in their care.
<table>
<thead>
<tr>
<th>Name</th>
<th>Mother</th>
<th>Grandmother</th>
<th>Father</th>
<th>Adopted</th>
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<tr>
<td>Beverley</td>
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<tr>
<td>Cathy</td>
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<td>Debbie</td>
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<td>Gina</td>
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<td>Kristen</td>
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<td>Laura</td>
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<td>Zoe</td>
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<td>Shirley</td>
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<td>Suzie</td>
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<td>Vicky</td>
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The table above makes clear that child loss is not an all-or-nothing proposition for these women. Though the sample is far too small to make any generalizations about the factors that presage child loss, it does highlight the ways this population has of defying simple explanations. Typically, one would look for factors like the ages of the children, the number of children, or the degree of stability in a woman’s life to explain why a mother might keep or lose her children. But within the above sample, Emma and Shirley, both of whom have multiple children still living with them and none in the care of others, belie the assumption that a woman cannot care for a large family while maintaining a (sometimes chaotic) drug habit. What the table does not show are the ad hoc
arrangements women make, particularly in times of crisis, to care for their children. Emma and Shirley were both able to give their children into the care of family members while they were either in prison or living chaotic lifestyles. Crucially, their families not only took the children, but were willing to give them back to the mothers when the mothers stabilized, which was not always the case for other women.

Some of the custody arrangements, like the adoptions outlined above, are the result of formal state intervention but, as with Emma and Shirley, *ad hoc* arrangements are far more common. Cathy’s partner felt that Cathy’s life was becoming too chaotic and asked her to let him take their son instead.

**Cathy**

It’s not sole custody…it’s something we’ve got between us. There’s no court case or custody or anything like that. We just agreed to do it that way…and that was when he was about one… Peter said “I want James to stay with me” because I started using drugs again and I thought it was the best thing for James, you know, to stay with Peter. Because Peter never touched heroin. He tried a few times, you know, stone (crack), but he would never, ever touch heroin. And he was more stable than me. He had his own place. Really, really nice flat. Everything there for James. Warm. Comfortable. Food. And I had already moved and had my own place. It was the best thing at the time for James. Of course, I missed him to death. And you know I was badly, badly missing him. It was the best thing for him, I feel.

Zoe and Laura both initially asked the babies’ fathers to look after the children while the women were in jail. However, both women found that, when they got out of jail, the fathers would not give the children back.
Zoe

I let his dad have him while I went to jail. I was sent in for a couple of weeks so I asked him to look after him, but then his mum interfered, do you know what I mean, so [he wouldn’t give the baby back.]

Although the father of Laura’s child had agreed to allow Laura contact with her child, he occasionally withheld contact or forbade her to speak to her child if they ran into each other on the street.

Laura

I’m still in the middle of trying to sort that out with my little boy, yes, I’m still in the middle of trying to sort it out… I’ve had to go through a solicitor, you know, to try and get access. But it’s better now that I’m in my own place because at least I can say that I can have him at weekends and he’s not going to be stuck in a horrible hostel, you know, so hopefully I’ll be able to have him here, just for weekends.

In each of the cases described above, the fathers were considered, by the mothers or by the authorities, to have enough stability to be able to care for children long-term. For all but five of the women in the study, and for all three women where the fathers had custody, the fathers of their children were also drug users. However, because drugs workers rarely ask men about their paternity, men are subject to significantly less scrutiny around their parenting than women. Fewer people (social care professionals in particular) assume that a father is sole carer for his children, so he is less likely to be reported to Social Services when he does not attend appointments or goes off his medications.

Matthew, drugs worker

I think with the males it kind of depends on, in part, on their role within, as parents. I mean, like the guy who came in yesterday, much of the focus was about the children, because that’s similarly
what his preoccupation is, he’s got such a central role, in fact the role with the children at the moment. Some of the other males who are parents are actively involved with their children, no, I suppose I confess that that, it doesn’t figure as prominently, but then they’re sharing the role, or even maybe to an extent not fully sharing the role, and so I think possibly the women do tend to get kind of, it does tend to be a more central focus with them, and that with some males it’s not highlighted as much in the contact I have with him.

As mentioned earlier, there were very few fathers who remained with their children for the long term. Fathers tended to be mobile between families, so they may have failed to arouse the notice of Social Services if they were seen to be more absent than present.

**Fathers and Domestic Violence**

According to the annual British Crime Survey of 2005/2006, 29 per cent of women aged 16–59 had been physically or emotionally abused by a current or former partner (Coleman, et al. 2007). This rate is slightly higher than other UK estimates, which place the rate of domestic violence against women at roughly one in four women (Walby and Allen 2004). In this study’s population, just over half (8 out of 14) of the women described episodes of domestic violence. In six of those cases, the perpetrator was the father of at least one of their children from whom they were now separated. Of the other two, one woman was still married to the abusive father of her children, and the other did not have a child with her former abuser.

In instances where women had separated from their abusive partners, some (four of six) were reluctant to stop the children from seeing their fathers. It is possible that the
adherence to traditional gender roles, in particular the perception of the need for a father figure, no matter how troublesome, may in part explain why, even though they suffered abuse at the hands of their partners, several of the women said that they would never stop a father from seeing his children.

Cathy

I was very scared and so was my mom for me because he was a lunatic, to say the least! He’d go into mad rages and just… I’d be out of it with black eyes and busted lip and I wouldn’t be able to come out… A brilliant father, I must say he’s brilliant with James. Very, very good, Very intelligent. Knows how to manipulate, you know. Very intelligent in that way. But, as a partner and husband, no. An absolute bastard! I’m sorry for swearing. But, he was very bad. Very violent and that. So, I thought, “All right.” Especially when I had my son, I thought, “No. I can’t let James be around this. Something is going to happen bad that I might not walk away from.” So, I split up with him and that was about 2 ½ years ago. James is three, three and a half now. I mean, he’s brilliant. He’s a good dad. He’s brilliant. He dotes on [James], yeah, and James dotes on Peter. And, I’ve never been one of those women who say, “Right, you’re not seeing your son, you’re not seeing your daughter.”… I would never, never deny James that, and I would never deny Peter that. I think its wrong for women to say that, you know, just because of what they’re going through.

Shirley

Then, like, [Tony’s father] decided he wanted to see Tony and that, so I didn’t stop him. He still sees her now, you know, she goes to her dad’s and that. Yes, I never stopped her seeing him, because he loves her, you know, she gets on with him. He’s good to her as well. Gives her money, and everything, birthday and Christmas. And I get on with him better now… he had to stop the drinking and the smoking, so he’s sort of changed now, you know, but I’d never have him back.
Kristen

I’ve been through too much with guys. You know what I mean? My first kid’s dad, we had all the fighting and beatings and all…[My daughter and son] stay now and again with him. He’s not … he’s strict but in the right way. Do you know what I mean? They’ll get what they want off of him …only if he knows they need it. It sounds like he’s all right…strict in the right ways.

These women felt that the violence was directed at them alone and would not be carried over to their children. Cathy, in particular, felt that she might not “walk away” from one of her partner’s beatings, but she did not see her partner as a risk to her child.

However, there is evidence that this is not the case. It is estimated that in 50-70% of homes where males are abusing the mother, they are abusing the children as well (Kantor and Little 2003; Kopels and Sheridan 2002). As Kate, a MSMS midwife, points out below, even if the father is not actually hitting the children, there are ways a child can be damaged by witnessing violence.

Kate, MSMS Midwife

[Women] say, “Yes, all right, he gave me a good hiding. Yes, all right, he slaps me. But he would never hurt the children.” Now they don’t understand, because they’ve never been, because it’s never been explained to them when they were growing up and they were watching their dad hit their mum, or their mum hit their dad, whichever, that it is detrimental to children to see their dad kicking seven shades out of their mother, or listening to it scared…We had one case where the father apparently thought it was okay because he’d locked the child in his bedroom so that he didn’t witness it. But in actual fact, the fear and the damage done to that child was worse because he never knew when all the noise stopped whether his mother was alive or dead. And he had to wait until somebody came and let him out of his room before he knew what the situation was in the house. And that kind of fear can be worse than witnessing it. At least if they’re seeing it, they know that their mother is still alive. So a lot of women don’t understand that. They say, “Well, he
would never hurt the children, I don’t know why they’ve taken my child off me. I’ve never done
anything wrong. And you know, he’d never hurt the children.” They don’t actually get it.

As can be seen above, in discussions and observations with the specialist
midwives and the women, it became clear that being a victim of domestic violence was a
risk factor for child loss. Though service professionals of all stripes understood how
difficult it was for a woman to leave an abusive partner,\textsuperscript{58} and the stated position of the
social services agency was that a woman would not be penalized for being a victim, in
practice the failure of a woman to protect her children from vicarious harm was seen as
an indication of her overall inability to parent overall and formed part of the case against
her when considering the removal of her children.\textsuperscript{59}

“Failure to protect” is a contested category among legal scholars in the child
protection field. The basis of “failure to protect” in regard to domestic violence and child
abuse cases where the mother is the non-abusing parent, relies on the assumption that
women are not only all-knowing about what happens to their children (regardless of
where the abuse takes place) but are also all-powerful in their ability to stop it (Hooper
and Humphreys 1998). One of the hallmarks of an abusive relationship is the abuser’s
ability to isolate a woman from friends, family or other support networks to ensure that

\textsuperscript{58} The most physically dangerous time for an abused spouse is when she attempts to leave her partner (Kopels 2002; Kantor 2003).
\textsuperscript{59} The Domestic Violence, Crime and Victims Act 2004 created a new category of crime (offense): allowing, or failing
to prevent, the death of a child or vulnerable adult. The Home Office guidance on the act gives these conflicting
recommendations on dealing with investigations in cases where domestic violence is also present: “Investigating
officers will need particularly to be aware that in some of the households where this offence has occurred, more
widespread violence and abuse may be present... Domestic violence may seriously undermine the confidence of the
victim and create an atmosphere of intimidation, shame and low self-esteem.” However
the guidance goes on to state: “ But it should also be remembered that this offence is premised on a duty to protect the vulnerable person from
harm... The fact that the defendant may be young and uncertain, feel intimidated or have suffered violence, will
not in itself be conclusive evidence that it was reasonable for the defendant not to take any steps to protect the
victim. In most cases (although not necessarily all) there will be steps, however limited, which the defendant could
she cannot leave him. The abuse can extend to control over the physical movements of
the woman and children and the household finances, leaving the woman with few
resources to escape the violence, or to force an abuser out of the home. Within this
context, a woman is expected to control her abuser’s behavior in order to protect her
children, even if she cannot protect herself.\(^{60}\)

Yet there is considerable vagueness about quantifying the harms that result from
witnessing violence. There are disagreements about the degree of “witnessing” abuse,
whether that means hearing a fight, seeing a fight, seeing the aftermath of a fight, or
being taken into collusion with the abuser against the mother. There are also
disagreements about how to quantify the harm done to the child as a result of
“witnessing” and whether that harm can be separated from the harms done to the
mother’s ability to care for the child as a result of the abuse (Holt, et al. 2008; Kantor and
Little 2003; Kopels and Sheridan 2002). Thus judgments about how “at risk” a child may
be can be based on factors outside of the woman’s control (ranging from the duration of
the abuse her partner inflicts to the degree of harm a particular social worker ascribes to a
particular aspect of domestic violence). Yet it is the woman who is brought to book,
through the removal of her children, for “letting” her situation get out of control.

At the same time, the midwives and other professionals occasionally had
information about a man that his partner did not. Sometimes men, in their capacity as
drug users, fathers of other children, or criminals, had prior contacts with the service
professionals of which a new partner would be unaware. As mentioned, the Vulnerable
Babies Service, to note one example, regularly contacted police to gain information about

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\(^{60}\) There is a long history of holding women responsible for the behavior of men. From the insistence that rape victims
are “asking for it” to the enforcement of wearing the burqa to prevent male arousal, men’s actions are routinely justified
as “natural” male behavior. Women are expected to adjust their behavior accordingly so as not to provoke men.
a woman’s circumstances and history. If the father was living with the mother when
decisions about parenting were being made, his history would figure into the process as
well. In more than one instance that I witnessed, the service providers uncovered the fact
that the male partner of a pregnant woman was a “Schedule 1 Offender,” meaning that he
had a history of sexually abusing children. In each case, the mother did not know that the
man she was living with was a risk to her children. The professionals had to decide
whether and how to inform the mother about her partner, while considering issues of
confidentiality, risk to the mother, risk to the children, and their own continued ability to
work with a woman who may have seen their intervention as invasive snooping instead of
a routine and protective function of their job. Ultimately, though, if a woman did not
separate from her risky partner, she would not get to keep her baby.

Thus the woman and the service providers are placed in a difficult position. If she
has her children removed, a woman feels she is essentially being punished for being a
victim of abuse. But, on the other hand, no one wants a child to live in a home where
there is continual violence or where there is a risk that the child will become a victim.
Yet, the evidence of the women in this study shows that they see fathers as a valuable
presence in their children’s lives, a belief supported by wider cultural expectations of
mothering and reinforced by research touting the benefits of two-parent families. Both
the women and the service providers are attempting to do the right thing by the children.
The women, however, are more likely to find themselves thwarted by forces outside of
their control.
Social Services Removal

When a drug-using woman has a child removed from her care, often the goal of the social services intervention is to get the woman to make significant changes to her lifestyle in order to prove that she can parent the child. Most often, she is required to show a period of stability and engagement with services (frequently drug and/or alcohol treatment services). If she does as she is asked, she can get the child back; if she does not, she will likely lose the child altogether. Over the course of this study, two women had children removed from their care at birth. In each case, the woman was required to make major lifestyle changes in order to get her child back. One woman was able to make the changes and one was not.

Kristen, a former heroin user on a stable dose of methadone, also had a severe drinking problem. She had two older children, both officially in their grandmother’s custody, though Kristen and her children all lived together in the grandmother’s house. Several years before, Kristen was living with a man and his child when the man’s child died while in their care, from an accidental methadone overdose.61

In contrast, Debbie was a heroin user who had not been on a stable methadone script for some time. She also had two older children who lived with their grandparents and whom she had not seen in several months. Debbie’s older children had been removed from her care because the couple with whom Debbie and her sons were living abused the

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61 Methadone is formulated as an extraordinarily sweet tasting liquid. Though users are told not to keep the methadone in the refrigerator, where a child may get to it, the medicine is more palatable when drunk cold. The bottles I saw in the refrigerator of one household did not have childproof tops. When I asked the mother why not, she said that the pharmacy supplies them that way. Given the known risks of accidental overdose in children, and the fact that childproof tops are widely available, the pharmacy is showing a shocking lack of forethought by either ignoring that the patient has children, or not asking about the need for a childproof top when dispensing. Yet if her child does get a hold of her medication and overdoses, it will be she, and not the pharmacy who is blamed for the child’s death.
children. It was judged that Debbie had been negligent toward her children by not preventing the abuse.

In both women’s cases, due to a combination of their past histories and current instabilities, the babies were taken into foster care straight from the hospital after birth. Debbie’s child spent a week in the hospital before being sent home with the foster carers, but Kristen’s baby was born ten weeks prematurely, so she spent two months in the intensive care unit. Because her baby was still in the hospital, Kristen was able to spend some of those two months with her child. Both women were able to meet with their daughters’ foster parents through the “contact visits” set up by Social Services. Contact visits, where mother and child are brought together at least once a week in a neutral location, are meant to promote attachment between the parent and the child in a safe, structured environment. The foster mother brings the child to the contact visits and the birth mother meets them there. The mother gets to have regular, supervised contact with her child to build or maintain emotional bonds, and the professionals have an opportunity to observe and evaluate the mother’s parenting skills.

Showing up for contact visits is an indication of stability and a demonstration of the mother’s willingness to comply with the directives she’s been given by the authorities. It is perhaps also a (subconscious) mechanism by which the “good mother” stereotypes are reinforced. A woman is meant to spend two hours focused solely on her child and nothing else. Without even the welcome distractions of preparing a meal or playing with other children, a woman must behave as though her 200th game of peek-a-boo is as exhilarating as the first. If she gets bored, or does not know what to do after an hour of reading stories, it is taken as an indication that she is not bonding with her child.
That said, for a mother who is distraught at having had her child removed, that short window of time can be precious.

Kristen

I used to have to travel to Tabitha every day. It’s out in Manchester, the other side of Manchester …but that’s because she was so small…They said to me, would I go to Tabitha, and I said, to be honest, I don’t mind where I travel to, I said, it could be to the other end of the world…I’ll travel for my daughter!

Kristen and Debbie each reported very positive experiences with their foster carers. Kristen’s went out of her way to reassure Kristen that she was not taking her place as a mother, and Debbie’s foster carer became an advocate when Debbie’s social worker was particularly insensitive.

Kristen

I met [the foster mother] the day [Tabitha] was going to the foster carer. I went to the hospital the day she was leaving. I went to see [Tabitha] before she went and I met the foster lady... She said “I’m not taking your baby away…I’m just looking after her until you get better.” She was really nice about it. You can get some who just look at you and think, “How could you be putting up with things like that?” She was a bit understandable. She was a nurse, as well, so that was good.

Debbie

[My daughter] was in hospital last week, for a week, she got bronchitis, and she stopped breathing. It sounds really bad, but thank God she was with the foster mum because that happened to her son, so she knew exactly what to do. For the grace of God... [The foster mum] got her to hospital, and she was fine.
Annabel, Foster Carer to Debbie’s Child

I felt really sorry for Debbie, and it was the first time I’d met her. …And we’d gone in this room in the hospital and [the social worker] sat down, and the first thing [the social worker] said was, “Now you do know mum’s a drug user, and she was using heroin five hours before Angel was born?” She said, “Is that why Angel’s ill now?” And I could see Debbie’s face, you know, and I just, I thought…if I’d have been Debbie, you could understand if Debbie had walked out then and walked under the first bus, or gone and took a load of drugs and topped herself…And I just turned round and went, “I’m sorry” [to the social worker]. I said, ”Can I just stop you there?”…So I said, “Hello, Debbie, it’s nice to meet you.” I said, “I know it’s not the nicest situation for you to meet me in, but it’s nice to meet you. Now can I just say to you now, Angel’s ill and it’s got absolutely nothing to do with you. It’s not your fault. Nearly every baby on this ward, the nurse will tell you, nearly every baby on this ward has got bronchitis and none of them are drug users. It has got nothing at all to do with you. It is not your fault. Debbie went, “Oh, thank God, thank you very much.” Later on the nurse said to me, she said, “You know, I couldn’t believe it. [The social worker] could have taken us to the side and told us that. She didn’t have to do it in front of Debbie.” She said, “It must have made her feel really bad.”

Annabel’s story is noteworthy because the nurse, whom one might expect to be as condemnatory of prenatal drug use as the social worker, was equally horrified at the social worker’s insensitivity. So much so that the nurse relayed the story to the MSMS midwives and other professionals working with Debbie to inform them of how little support Debbie was getting from her social worker. Unlike past research, which has highlighted the bias from professionals faced by drug-using mothers, more often than not while working in Manchester I found the professionals to be highly sympathetic and eager to support the drug-using women they encountered on a regular basis. There were, as might be expected, pockets of prejudice against drug users, but the tide was
overwhelmingly turning toward providing women with a supportive, rather than stigmatizing, environment.

Unfortunately for Debbie, a few months after this incident, she lost her bid for custody and the baby was put up for adoption. It is somewhat prescient of Debbie that when I mentioned to her how positive and motivated she sounded in our interviews she replied, “Yeah, I always do,” meaning, I think, that she had been down this road before and knew where it might lead. Though the worker from her contact visits said she was “doing everything right” with her child and attending all her visits, her drugs worker later told me that she felt Debbie had never fully achieved control over her drug use.

*Juliet, Drugs Worker*

She never really quite got it together during any of that, I don’t think. Yes, I mean, I’m sure she went kind of more off the rails after it, but she was never on them properly.

This case serves as an example of the subjective nature of the judgments made about drug-using mothers. One of Debbie’s workers thought she was doing perfectly well, while the other thought she did not have her act together. This example highlights the fact that, despite the guidelines set out earlier in this chapter for successful mothering in the eyes of authorities, the decisions to remove a woman’s child are ultimately not based on a set of clear rules or tick boxes of concrete achievements. Women must convince quite different individuals that they are whatever those individuals expect them to become.

*Kristen*, on the other hand, was able to make the necessary changes and regained custody of her child six months after the child had been put in foster care. When I interviewed Kristen while she was still pregnant, her answers were extremely short and
almost inaudible. She disappeared from the study for almost a year after the birth of her child, and only resurfaced a few months after she’d regained custody. After she got her child back, Kristen remained with the study for another year and was much more confident and voluble in her interviews.

Kristen

I fought for her in court and now I’ve got her back. I’m off the drinking and all of that, just to prove to them basically. And now, I’ve got no problem now with them. They still have me report in over Tabitha. But, the social worker, she’s brilliant…she’s really, really nice. She’s lovely. I had to do…Like a 12-week course\(^{62}\), I had to do so they could see how you are with the baby, if you are able enough to look after the baby, meet the baby’s needs, things like that. They did a good report and they approved me…Social Service does a report for the court and that, as her guardian. [My social worker] came to see me not long before I was due back in court, and she’s even said she’s very happy with how I’m doing. My social worker’s really happy I’m doing well.

There is no way to know exactly why Kristen succeeded where Debbie failed, but there were some significant differences between the women’s circumstances that highlight the different challenges each woman had to overcome. Each woman’s older children were in the care of their grandparents when the woman became pregnant with her third child. Kristen, however, lived with her older children, whereas Debbie did not. Kristen was able to spend two months getting to know her baby; Debbie was not. Though she had a drinking problem, Kristen was on a stable dose of methadone; Debbie was not. Kristen had a supportive social worker and lived with a supportive family; Debbie did not. Neither woman was still in a relationship with the baby’s father. But Debbie’s ex-partner was fighting her for custody of the child and broke into her home to assault her

\(^{62}\) I was unable to discover a parenting “course” that Kristen was on. Rather, I think she is referring here to the contact visits described above.
physically a few weeks after the baby was born. Looking at the differences, one could persuasively argue that it was Kristen’s stable and supportive family environment that allowed her to persuade the authorities that she was a fit mother, whereas Debbie had such an avalanche of challenges it would have taken a battalion of supporters for her to overcome them.

**Family Support**

Family support is not unreservedly positive, nor even unreservedly supportive. Family relationships are complex and layered and, for this population in particular, often fraught with troubled histories that make relying on family as risky as rejecting it.

When social services are attempting to judge how well a woman is coping or how much professional support she needs, they will often make those decisions based on the family support network she has available. But the pressures these women place upon their families (and vice versa) make these relationships fragile and conditional. The cycles of addiction, recovery and relapse can be exhausting for a family. Cathy talks about her relationship with her sister who, because of her drug use, has stretched the bonds between herself, Cathy and their mother too far.

**Cathy**

Sometimes the best times I had with [my sister] have been when we were doing drugs. And the best chats and conversations and heart to hearts…you know, we’ve had some really close times on it. And some really, really horrible fighting times as well, you know? She’s robbed me, as well, you know. She’s pinched (stolen) things and pinched things out of the house and things like that. So, that’s when it really got to a level I said, “All right, I’ve got to detach myself.” Even for my mum’s sake. My mum said, “[Your sister] can’t come in. She’s not allowed a key anymore, she can’t come in.”
Cathy describes her own relationship with her mother as very close but acknowledges, “[Mum’s] come to breaking point and had enough of everything, but she’s always been there for me.” Unfortunately, a few weeks after our interview Cathy’s mother was pushed to breaking point again and threw Cathy out of the house they were sharing. Getting kicked out of a family member’s home was a fairly common occurrence for this population of women.

Rachel

Well, we lived with [my partner’s] mum and dad when we first got here. And then they found out about the drugs so they kicked us out. And then we moved in with his uncle. And then we got kicked out of there and ended up in a hostel place.

Although most of the women in the study described their families as being currently supportive, several of the women came from homes that were far from supportive when they were children (though it should be remembered that none of the women “blamed” their childhoods for their drug use.) They came from homes where they witnessed domestic violence between their parents (4 of 14), had parents who abused substances (5 of 14) or where they themselves were sexually abused (5 of 14). In the cases when women’s own parents were drug or alcohol users, the women saw the use as problematic partly because it forced them to assume responsibility for their siblings when their parents were unable to do so.

Beverley

[Mum was] going out, and meeting fellas, and things like that, but she didn’t, like--well, yes, she probably did, like-- neglect us a bit, not neglected, but you know, like, I think because I was there, you know, she thought I’d kind of do it, sort of thing.
Rachel

After my dad died she went, you know, she just went a bit, she went and had a bit of fun, you know, because she couldn’t have that when he was alive, you know, she was stuck in the house, and she wasn’t allowed out the door, and stuff like that, so when he died she found a new lease of life and sort of forgot about, you know, her kids.

Debbie

My mum was a big drinker when I was younger, so we grew up with that sort of, you know, very strange. Because my mum was spending all the day on drink and everything, so me and my elder sister had to bring up my younger brother and sister. So it was a very strange childhood. Yes, I didn’t really have friends, and I couldn’t have anyone to the house. You didn’t know whether mum was drunk or not.

Women who discussed being sexually abused as children (5 of the 14 women, though not exactly the same 5 who described substance abuse by their parents) also talked about how their families ignored or denied the abuse and did nothing to stop it.

Vicky

It was my father that abused me, yes, eight years old I was, he messed about with me, up to the age of 16 he did it, but I was told it was all in my mind... It was, “Oh, your dad wouldn’t do that to you.” I mean, he would give me anything I wanted, and whatever.

Laura

Because my mum was drinking and so I was getting abused [by Mum’s partners]. So my dad got custody of us. But then my dad didn’t want us. So my sister went back to live with my mum. But I went in a psychiatric unit. So I was in and out from age 11... Just because of everything that was going on and no one was listening. I just had enough. So one day I just got the tablets and
[overdosed] and that's when they started taking me seriously and giving me physical examinations and found out that things had been going on that I'd been saying had been going on and they were worse than what they thought they were.

**Zoe**

Especially when your family don’t believe you. Do you know what I mean? They only started believing me, it was about ‘93, ‘94, when they decided to believe what I was saying. Only because I was in jail, and they found out. [My step-dad] remarried and [his new wife] had a 12-year-old and he started abusing her, so they decided to believe me then.

Over the three-year course of the study, four women “fell out” with their families significantly enough for them to sever all contact for as long as between two and six months. All fourteen of the women had lost contact with their families for long stretches at one time or another. Despite the breaks, women and their families seemed to subscribe to the idea that “blood is thicker than water” and the families would, eventually, take their daughters and sisters back into the fold. Interestingly, the women saw these periodic breaks with their families as anomalies in an otherwise supportive relationship.

**Gina**

We’re actually very, very close, you know. Over the years it hasn’t always been that way because, you know, one thing or another, with me usually, but when I’ve needed them they’ve always been there, you know, no questions asked sort of thing.

**Kristen**

[Mum] was very, very supportive. For all that I’ve been through and that, she’s always been there.
Though women’s relationships with their families were often complex and occasionally painful, “the family” remained a source of stability and safety when life became too chaotic. While some women might call on their girlfriends to support them in a fight with their partners, the women in this study said they had few friends outside of their drug-using circle. These transactional friendships, built on mutual drug use, were also built on distrust. Women did not trust their “druggie friends” not to steal from them or do them harm if it was expedient to do so. When a woman was trying to get off drugs, as all of the women were at some stage, the only support network she could call on that was not exclusively part of her “druggie” circle was her family. This meant that the loss of family support, even for a short time, could be devastating for these otherwise highly isolated women.

For many of the women, family support was invaluable for immediate short-term interventions. Gina, whose drug use caused her to lose custody of her three older children, had a particularly upsetting fight with her husband, Mark. To cope with the pain, she decided to score some Valium despite the fact that doing so could have meant risking the custody of her new baby girl.

**Gina**

I got on the bus, I was going to get a load of Valium, I was on the bus and part way down to where I was going to get these Valium, I phoned my sister and I told her what I was going to do and she said “I’m about five minutes away. Just get off the bus, don’t go, and I’ll come and get you.” And it was raining and I was just all tears down my face and she just bundled me in the car, took me to her house and we had a good talk and….because I would have just taken a load of Valium, drank and just back to square one. That was a really hard point. It was wrong.

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63 It is highly probable that the women in the study were as distrusted by their “druggie friends” as they were distrustful of them. The nature of drug-using friendships was described as one of convenience, proximity, and supply and demand, rather than any deeply shared experience or perspective.
For Gina, having a family to rally around her gave her the strength to resist going back to drug use, and gave her an alternate coping mechanism for the sadness she was feeling. While Gina might have reactivated her old drug-using network to score some Valium (and they were more than happy to have her back), she called her sister instead, to help her avoid doing what she knew was wrong. But even Gina makes a distinction between the kind of strong support she had in that instance and the nebulous and perhaps even grudging support given to drug users by overstretched family members.

Gina

For the first time it was the genuine support of my sisters. Because they’d seen how hard I had been trying over the past few years, they were genuinely feeling for me and it felt good that they really were. That was what stopped me. Because for the first time they genuinely were with me. I don’t know if that makes sense? I know you can say you’ve got support, but no, they were feeling it as well. I must have looked a mess. They must have seen that I was heartbroken. For the first time in a lot of years they were there with me and they were on the phone constantly. Other family members as well, because in my family there is a lot of women and word obviously had got round and the phone was going all the time.

Perhaps because of the immediate and non-drug-related nature of Gina’s troubles with her husband, the whole family was willing to invest the time in “constant” phone calls of support. In this instance, the support Gina received was, as she points out, conditional. Because her family was able to see that she was making real progress with her drug use, they were more willing to support her through a difficult period.
Family support for this population often comes down to this type of crisis support. Women spoke of not being close with their families but would insist that their families were “there whenever I needed them.” The needs to which they were referring are these moments of crisis when the needs and the remedies are clear-cut and short–lived. As mentioned in the previous chapters, women described the extraordinary measures family members took to get them off drugs: Mary’s family “kidnapped” her; Cathy’s mother “physically dragged” her back home. Yet women also told of how they did not feel well loved or protected by their families over the long term. Mary, who lives with her mother, feels that her mother never gave her as much love as she could have given. When a woman went to jail, her family was willing to take in her children, but was not always willing to support her in mothering them when she got out. For many of the women in this study, “genuine” family support, the ongoing day-to-day guidance, assistance and display of unconditional love, was a rarity.

**Grandmothers**

As seen, despite its faults, women tended to see the family as a safe haven to return to when all else failed. In particular, women’s first pregnancies, coming as they often did after a drug-induced estrangement, provided women with an opportunity to reconnect with their families. Indeed, pregnancy appeared to be one of the main crisis points where women were able to successfully elicit family support. Six of the fourteen women in the study found that a pregnancy or a baby gave them the impetus to reestablish ties with their family.
Debbie

I was pregnant, and the baby’s father was in prison at the time, and it was his father’s girlfriend who phoned my mum and said, “Look, you know, she’s doing all right, but she’s pregnant, and she wants to see you.” And so we met up at MacDonald’s…but they were brilliant, they were just really understanding, and, you know, [Mum] said, “Even though you’re on drugs, you know, you’re still my baby, and I still love you.” I was like, “Oh Mum! Yes.” So it was all right.

Beverley

Just like, since I’ve had the baby, since I’ve been pregnant they’ve started speaking to me, they’ll speak to me like civil, do you know what I mean, like they used to speak to me…I think my mum and everyone thought I was going to be like, you know, won’t be able to cope, because my mum was saying like, you know, “Come and stay here with me.”

Not only were families called upon to support a woman with a new pregnancy or a baby, but frequently, women saw their families as a safety net for their children if anything went wrong. Putting a child “in care,” – i.e., foster care – was seen as a last resort, to be avoided if at all possible, whereas a grandmother was a useful temporary guardian or babysitter if women felt they were slipping into old habits.

Shirley

I’d already had Tony when I was with Chris, and then, I wasn’t even on the drugs when I had Tony, yes, just started dabbling then. I think she was about two, oh, she’d got to three, two and a half, you know, when I moved to my other house, and that’s when I decided, she was just over three in the nursery, and I thought, I’d best send her to my mum’s to live, started, you know, my house was getting a bit, I was having friends in and smoking (crack).
Laura

If it got to the stage that I’d messed up or whatever and I couldn’t look after my kid and it was affecting my child’s welfare, then I wouldn’t put her in care, I’d put her with family but I wouldn’t put her in the homes. But I’d get support from within the family. But I won’t let that happen.

The professionals, from social workers to midwives, generally said that it was better for everyone if children were placed within the family if the mother could not care for them. In theory, this was to allow the mother and child to have some contact over the long term, particularly if the mother was able to regain some stability in the future. However, this sometimes resulted in some convoluted formulations of custody arrangements, where, though the grandmother had formal custody of the children, the mother still had daily contact with them. Sometimes the mother, like Kristen, was living in the same house with her children. Or sometimes, the mother and grandmother lived next door to one another. This brings into question the notion of “removing” the child from the mother’s care. Is she simply having her legal responsibilities removed for the sake of the authorities’ own sense of well-being? If there is really a concern that she will damage her child, why is she allowed so much contact with it? Or it is just that, in order to parent, the woman needs extensive long-term support? Is the custody arrangement just a means of formalizing that long-term support relatively cheaply through a family member rather than through a state agency? Is the state, in effect, placing both mother and child under the care of the grandmother? In some cases such arrangements are messy, to say the least.

Kate, MSMS

We had one [case] that everything was done, and this woman was going to take this child. Then it turned out that it was OK so long as this woman, the mother of the child, was never left
unattended with the child. So the grandmother had to be there all the time. But then this woman couldn’t live with the [baby’s] grandmother, so she was living next door with her [own] grandmother. Are you with me? So you’ve got a grandmother, a great-grandmother, and the mother, and the baby. So the baby can’t stay with the mother so the baby’s staying with its grandmother. And the mother’s staying with her [own] grandmother next door, but because [the baby] couldn’t stay there, then the mother can have it at night. So then the mother of the child was taking [the baby] overnight and keeping it with her in her room overnight, and taking it next door and giving it back to her mother the next day for care during the day, and I’m like, well, where does it say that it’s not going to be in danger overnight but it is in the day?

Several of the professionals that I spoke to suggested that the shortage of money and of qualified foster carers in the Northwest region of the UK made the grandmothers a more attractive option for child care than they might previously have been considered. A growing body of research into so-called “kinship care” has also raised this issue (Broad 2007; Burgess, et al. 2010; Sinclair 2005). But as the research is beginning to show, kin need as much support with caring for additional children as do traditional foster carers (or indeed disadvantaged mothers). Thus the financial incentives for using kinship care may fall away as its cost becomes comparable to foster care.

Despite its conditional nature, the ready availability of family points up an inherent shortcoming in any attempted government programs. For all the good it may be able to achieve, no program can replicate genuine family support. This is not because the programs are not well intentioned or even well designed, but rather because no program will have the longevity of family. Governments come and go, and the support programs tend to come and go with them. To be sure, government programs do not have the extensive emotional baggage that families do, but family has a finite caseload and lower
staff turnover. Getting support from family is often, in the short term, easier than “accessing services.” Family does not necessarily pose the same risks of child loss for a woman as a service provider may. Family is an excellent model of the “joined up working” that has come into vogue in the social service sector; family is a one-stop-shop for counseling, income support, housing support, and child care.

However, the grandmothers in this study were not all warm cookies and knitting circles. Four of the grandmothers were described by the women as having “gone off the rails” themselves when their own children were younger. Several of the women felt that they had not been well parented when they were younger and had modeled their own parenting practice in opposition to how they had been parented. Even the professionals felt that the grandmother was a potentially problematic option as foster carer.

**Juliet, drugs worker**

You know, there can be an absence of parents, or you know, parents who haven’t been parented well themselves. You know, there’s almost an assumption by Social Services, well, you know, if all else fails, then, you know, perhaps the grandparent will take them, and I think, “Whoa! I don’t think so.”

**Gabrielle, MSMS midwife**

What worries me about that situation sometimes is, if I feel, if I’m the mother of this new baby and I feel that I’ve not been parented properly and they’re going to give it to my mum, then how does that make me feel? Lots of things. Anxious, because I’ve not been parented properly. And, you know, “What if this happens again?” And I’ve had that. But also about, “Well, how can she love this baby, and look after this baby, when she couldn’t do it for me?” So again, it’s about that woman’s self-esteem has now gone a bit lower. So is that going to make her more likely to then go off on a binge or, you know, increase her drug-taking behavior, so then she can’t show that she’s a fit person to take this baby back?
Yet some, though not all, of the professionals believed that the grandmothers might have mellowed with age. Like the drug users who age out of a chaotic life of drug taking, perhaps these grandmothers “aged into” mothering. Time, and possibly some service interventions, might have allowed them to get their lives on a more stable footing.

**John, social worker**

It could very well have been that when the grandma was parenting the mother, because of the circumstances involved, she could have been living in a homeless family herself or whatever. There could have been extenuating circumstances impacting upon her parenting at the time, you know. If you’re looking at placing the grandchild, if you like, with the grandparents at this stage, you’d be doing like an assessment now of the grandparents and are they able to parent at this stage, you know. They could be in a different family setting completely. You know, they might have bought their own house now, live in the middle of Cheshire or somewhere, you know. You don’t know. You need to look at the circumstances now.

In some cases, of course, grandmothers who struggled when they were younger simply had the benefit of experience to guide them now. As Kristen’s mother put it:

**Kristen’s mother**

You’ve no choice but to learn. You make mistakes, then you make them back up again. That’s it.

You learn the mistakes you make the first time so you don’t make them the second. That’s it.

Women, too, sometimes remarked on the difference in the grandmother’s parenting of their grandchildren compared to their parenting of themselves.

**Gina**

It sounds awful, but I think my mum’s learnt a lot as well, you know. And I think, you know, she is good with the kids … [Mum’s] letting them, she is good with them. I can’t really fault her, you
know, she was absolutely crap when it came to me, I think, you know, but I think, you know, but there are a lot of things that need to be said, I need to say to her, and you know, I’m sure she’s got to say to me…I feel that I never really had a mum, you know, I don’t, and there’s a lot of stuff. I feel totally betrayed by her actually.

Rachel

I have to say that she has been a lot better with my kids than she was with us, you know, because she now lives with her boyfriend, and he’s brilliant with my kids. Even though we don’t get on, he’s very protective of them, and they get everything they want. They go on holidays, and they’ve just been to Lapland. They’ve just been on holidays. So yes, they’re getting a better childhood than we did.

However, having a grandmother take over care of the children can prove to be as risky as engaging with social services. Rachel and Debbie, though they “voluntarily” gave their children into their mothers’ custody (with significant prompting from social services), each became estranged from their mothers and their children over time. In each case, the grandmothers took on the grandchildren but were either unwilling or unable to also care for the mothers in the long term. Rachel’s mother refused to speak to her, and her mother’s boyfriend would not allow Rachel in the house to see her three children. In order to speak to her children, Rachel needed to call them when they were at Rachel’s sister’s house.

Rachel

My oldest, she’s 13, Kira, will be 8, and Chloe will be 6. I spoke to my eldest on the phone for ages. And Chloe was quite young when I left so she probably doesn’t really remember me much. But I spoke to them all and it was nice, because I’ve not spoken to them for a good two or three years, so yes, it was nice… I don’t get to speak to the kids as much as I’d like to because my
stepdad, you know, he doesn’t, I don’t think he wants me speaking to them, and they, obviously they live in his house, so I can’t ring the house, because if I ring the house and he picks the phone up he’ll just put it down or something. So I ring my sister’s and speak to them when they’re there.

On occasion, women have fought their mothers in court over the custody of the grandchildren. Laura and Gina both found themselves in a three-way custody battle with their partners and their mothers for custody of their children. In Gina’s case, the result was not only the loss of formal custody, but also, the separation caused a deeper sense of loss in her role as the children’s mother despite the fact that she sees the children regularly.

Gina

My kids have been away for a couple of years now maybe, getting on for three years, and it’s become blurred now … I’m not their parent, my mum is. Especially with the little one. She was only still very little when she went, and she’s my mum’s kid, you know. And like there’s been lots of tears about it. How I feel I’ve lost them. I’m not their mother anymore, and what have you. And my mum, she knows what’s she’s doing like when I’m there at Christmas and all that, and my sisters have had to word her up, tell her, and you know, she always accidentally on purpose says, “My kids.” You know? And she knows that it hurts me.

Other women asserted their motherhood over some, but not all, of their children. Zoe makes a distinction between her daughter who was adopted away as a baby, and her son, whom she still sees, though he has lived with his father for the past eleven years, from the age of two.

Zoe

[I’m] Not [a mum] to my girl, because I’ve never seen her since she was a baby. But to Red, yes, I’m his mum, even though he calls his dad’s girlfriend Mum, he’s still mine. When he’s here he’ll
slip up and say “Mum,” you know, when he’s talking about her, and then say, “Oh, Bianca.” So I goes, “Yes, I’m your mum.” I goes, “She might have looked after you, but I’m your mum.”

Though Zoe says she is not a mother to her daughter, in all of our conversations Zoe would mention her daughter, and specifically, her daughter’s current age or birthday. Zoe was unable to talk about the reason for her daughter’s adoption but her memory of her daughter’s birthdays perhaps points to the larger sense of *loss* in child loss.

**Gabrielle, MSMS midwife**

I’ve got one of my women who has now kept a second child; the first child was taken away from her. And she has sent birthday cards and letters, and Christmas cards, to this child [for] eleven years now. So every time she’s bought him a birthday card she’s bought two. So she’s written one and sent it to him, and she’s written one and kept it. And she keeps it in a box, and every letter she sends she writes two of, and she sends one on to him and she keeps one in her box, and that’s her box, because that’s her son, and that’s all she’s got in that box. And a lot of it as well is around if he comes looking for her. If he’s never received any of those, which she suspects he hasn’t, she can say, I sent you that for your first birthday, and it’s heartbreaking, you know, it’s really tough.

There are times when a woman is given no chance of being allowed to mother her child. Her combination of past and current problems may be too great to overcome or be deemed too risky for a child. There were women I met, though none who agreed to be formally interviewed for this study, who had lost two or more children into adoption at birth. It is these women who highlight the public nature of pregnancy most clearly. When a woman is pregnant, a huge number of services coalesce around her. But when she loses a child, the services start to fall away almost immediately.
John, social worker
When the child, for whatever reason, has to go outside of the family -- it could be that there isn’t any suitable carers, and the child has to go outside -- if you like, it is like a bereavement. Very upsetting for the mother. But sometimes, you know, they see it as a necessary evil, if you like, while they address their own needs. But what I have found, in a lot of circumstances, is once the child has been removed, the parent doesn’t have the impetus to move forward and get that support that they need. They tend to lose it quite quickly, and they go downhill very quickly.

Kate, MSMS midwife
I think [support] disappears a lot quicker when the babies don’t go home with them, and I think that’s more of a problem. Because, you know, if she takes that baby home, to a certain extent, there’s quite a lot of services still involved. And that’s another role, another part of this role, is coordinating all those services as well. Making sure that, sometimes, you’re the link person between them all, between three or four different services. I find it more frustrating when they don’t take the baby home, because they have nothing. They don’t have a health visitor. They don’t have a midwife. They don’t have anybody. So they go home to nothing. That is, it literally is nothing. Nobody.

Women are left to face the devastation of child loss alone, with little acknowledgement that they are suffering bereavement but with all the stigma of being deemed an unfit mother. Nonetheless, the lack of services for bereaved mothers highlights a little acknowledged facet of even the most supportive service provision. The goal of the state in providing housing support, drug treatment, midwifery care, etc., etc., is to secure the best possible carer for the child, not to improve the life of the mother. The mother is compelled to action for the sake of the child. Any benefits to her are a fortunate byproduct. That is not to say that individual providers do not care about the women. On
the contrary, they care very deeply, but at the level of the state, services for the drug-using mother are primarily to protect the welfare of the child. The job taken on by the state in providing the various services is to secure for the child an adequate mother. There is no distinction for the state between the birth mother and any other carer. Thus, when the birth mother is deemed unsuitable the services, following the child, fall away from the mother.

For a drug-using mother, the loss of her children also demotes her from having the universally acknowledged “mother” identity to the universally reviled “druggie” identity. While she may cope with her bereavement through a return to drug use, she may also attempt to regain her motherhood identity through a new pregnancy, where, by dint of trial and error and a lot of heartache, this time she can “do it right.” Indeed, the data throughout the study show that women spend a great deal of time reflecting on the kinds of mothers they want to be and developing strategies for how they will achieve good motherhood. From budgeting their cash to ensure that their children “want for nothing” to “keeping that mother bit normal” through consistent bedtime routines, the drug-using women in this study worked hard to fit within dominant mothering ideologies. They strive to “be there” for their children, to love them and to care for them to the best of their abilities. When they fail, it is not for lack of trying.
It is she, finally, who is held accountable for her children’s health, the clothes they wear, their behavior at school, their intelligence and general development. Even when she is the sole provider for a fatherless family, she and no one else bears the guilt for a child who must spend the day in a shoddy nursery or an abusive school system. Even when she herself is trying to cope with an environment beyond her control – malnutrition, rats, lead-paint poisoning, the drug traffic, racism – in the eyes of society the mother is the child’s environment (Original emphasis).

Adrienne Rich, Of Woman Born p53

When we criminalize certain drugs we are, in part, criminalizing a feeling: the feeling of being “high” or “out of it” as opposed to being “in control.” Legal drugs, aptly named “controlled substances,” become problematic and even criminal when used outside of a controlled context. Alcohol is legal, but there is also a limit above which one is legally considered too drunk to behave responsibly. Valium when prescribed by a doctor is legal, but taken out of that context it becomes a substance of abuse. Taken to mitigate an illness, the opiate morphine is legal, even if you enjoy it. But the same quantity of morphine, taken solely for enjoyment, is illegal. A major “problem” with drug use is not simply that some drugs are illegal, but that purposefully taking oneself high above “normal” social rules and behaviors is socially unacceptable to the point of being criminal.

One can argue that getting high (or the endless pursuit of a good high) leads people to do despicable things – rob, steal, lie, cheat – but are those necessarily the outcomes of the high or just the outcomes of funding the drug use? What if funding is not
a problem? Does anyone care if wealthy people get high all the time? When the fashion model Kate Moss’s crack habit was discovered by the media, she was dropped from several prominent ad campaigns (H&M, Burberry and Chanel, among others), branded a “crack mom” by the tabloid press and threatened with arrest and the loss of her child. A year later she was the winner of the Model of the Year prize at the British Fashion Awards and was (again) one of the highest paid models in the world, and the police had dropped all charges against her. Her wealth and position ultimately protected her from the difficulties poorer women find themselves in. Financially and socially, poor drug users are targets of state intervention, are said to possess certain distinctive personality traits (borderline autistic, conniving, thieving), and are perceived to be a threat to their children and society. Within Kate Moss’s income bracket and profession there is a tacit acceptance, if not an outright expectation, of drug use. While the public may enjoy the titillating scandal of “narcotics allegations,” the consequences often last no longer than the headlines. More than a few politicians, celebrities and musicians have been “caught” using drugs, and although they may lose their jobs, they rarely lose their children. They can retreat behind a barrier of lawyers and public relations people who (ironically) claim the privilege of a “private matter” to shut out unwanted attention. They are quickly and thoroughly “rehabilitated,” making them perhaps some of the only people to ever successfully be so.

As the preceding chapters make clear, poor drug-using mothers are granted little privacy as they face a host of complexities which, while not unique to drug use, are certainly exacerbated by it. Shit-Life Syndrome – encompassing poverty, sexual abuse, domestic violence, and a lack of education, decent housing or prospects – marks these
women as more similar to other poor non-drug-using women than it does to any wealthy
drug user. But it is their drug use that defines them in the eyes of the public and of the
state.

Drug use lends an urgency to interventions into their pregnancies and child-
rearing practices that is not present for non-drug-using women in similar socioeconomic
circumstances. Drug use is seen as placing their children at higher risk for health
problems in the womb, and at higher risk for social problems when they come out of it.
Yet we have seen from the medical evidence that the chemical compositions of illegal
drugs make them no more, and often somewhat less, harmful to the fetus than legal drugs
like tobacco and alcohol (Frank 2001). Many of the social ills the women and their
children experience, like domestic violence or housing and financial instability, are not
unique to drug users and may be just as harmful to children. Still, poor drug-using
women are cast in the popular imagination as “bad” mothers whose refusal to give up
their hedonistic pleasures irreparably damages their innocent children. However, the
women in this study did not experience their drug use as wholly pleasurable. Drugs were
a combination of medication for physical and mental ailments, a bad habit, and an
occasional (though guilt-filled) reward for good behavior. The daily grind of drug
addiction held little pleasure, much less the wild abandonment envisioned by so many
moral crusaders.

Ultimately, it’s about control. For drug-using mothers, everything hinges upon
their ability to maintain control – control over drug use, certainly, but also control over
their environments, their partners, their children and themselves. If one element slips, it
can put everything else at risk. A poorly maintained home, a violent partner, or even poor
school attendance all raise questions about a woman’s ability to care for or control her children sufficiently. The ultimate loss of control is epitomized by the smackhead. The smackhead label – dirty, hedonistic, and uncaring – awaits any woman who cannot control herself and those around her. Whereas a “heroin user” is entitled to services and sympathy as she battles her illness, no one has any sympathy for the smackhead.

There is a persistent tension between the women’s self-imposed need for control and the control both demanded and imposed by the state agencies that work with them. Although women know that they need to maintain control in order to maintain their status as mothers, there is a certain fatalism revealed in the way they talk about their lives, as though they have no power over what happens to them or their children. From being “caught pregnant” to living in “chaos,” there is a continual sense that things “just happened” to them and there was little they could do to combat them. Addiction “just happened” because so many people around them were using that it was inevitable they would try it too. Getting off drugs will happen one day when they “just wake up” and won’t want to use any more. They get “caught pregnant” because their partners forbade contraception or just wore down their resolve. Their children may one day use drugs but there is “nothing” they can do to stop them.

Even the provision of services, which are predicated on an aspiration to get one’s life under control, can end up reproducing conditions of dependency. At almost every stage of service provision, a woman must demonstrate her willingness to take control over her life, while at the same time relinquishing control over much of it. Financial benefits may be increased, decreased or withdrawn depending on who is doing the paperwork or which party of government is in power. Or, as happened in Manchester, the
private owner of several homeless families facilities can go bankrupt, suddenly forcing over 150 families to relocate and wreaking havoc with the housing waiting lists. Whether or not a woman keeps her children can feel like a matter of luck, dependent on whether she is assigned a good social worker or a seriously awful one. A woman’s daily routine is filled with appointments scheduled at her providers’ convenience. Even though she may be given an opportunity to choose from a limited pool of pre-selected properties, her home is essentially assigned to her. Her relationship with her partner may be dictated (albeit sometimes with good reason) by an outsider’s judgment of his character. And throughout, her right to mother is always at risk, based on someone else’s judgment of how well or how badly she is doing at being in control. It is little wonder, then, that women attempt to wrest back some of this control even as those they petition in their pursuit of motherhood demand that it be relinquished.

**Little Boxes**

A complaint I heard repeatedly from service providers was that women liked to keep the providers “in their own little boxes.” In other words, women would tell only certain aspects of their story to certain providers, so that no one provider had a complete picture of the women’s home life, drug habit, child rearing, family history, criminality or health. If, in a Foucauldian sense, knowledge is power, then by limiting the knowledge individual service providers had about them, women were limiting the power those providers could have over them. As mentioned in Chapter 3, the “lottery” nature of service provision means that the level of services one gets is dependent not only on the location of services but also on the individual idiosyncrasies of a particular provider.
Trying to negotiate a complex service system, women must also attempt to negotiate a complex series of individuals who come with their own prejudices and predilections. Women attempt to exercise control by “keeping everyone in their little boxes” because giving each professional what she/he wants is the best way to keep their children.

Returning to a quotation from Zoe in Chapter 3, “If you do what they ask you to do, you end up with a baby, but if you don’t and you work against them, they take them away.”

In turn, providers attempted to combat being boxed-in through joined-up working and information sharing. The providers judge the level of help and support a woman’s needs based on workers’ own experience of the woman, their knowledge of the larger population, and the input of other workers who have previously encountered the woman. Thus, both the workers and the women are involved in a delicate negotiation of identity and power, each party revealing only a fraction of what she/he knows in order to achieve maximum benefit with limited engagement. Women neglect to mention past histories of criminality or child loss, and workers neglect to mention the involvement of the police. Women want services without having to concede their autonomy, and workers want compliance (and results) without having to add to their overstretched workloads or jeopardize their professional networks and judgment. The negotiation is vital to women’s survival because the services are vital. The women in this study were overwhelmingly on public assistance and reliant on the state for basic needs like money, housing and transportation. Nonetheless, there is an infantilizing aspect to these services, which demand obedience and yet are seemingly capricious in the ways they mete out rewards and punishments; this woman got a new house and that one didn’t, this one got to keep her baby but that one did not, this social worker says yes but that one says no.
Survival Performances

To navigate the caprices, a woman engages in a series of performances, becoming a different person for each of the different providers she encounters. For the drugs worker she is a chaotic woman trying to achieve stability, for the contact worker she is the wholly devoted mother willing to do anything for her child, for the midwife she is the compliant patient following doctor’s orders. While many of us engage in a similar type of performance, such as maintaining separate professional and private personas, for these women the risks of failing to perform are higher. If I fail to convince other mothers that I share their values and goals, my children’s social lives may suffer but none of the mothers will attempt to have my children removed. But a drug-using mother who fails to convince the service professionals that she shares their (potentially disparate) goals, faces precisely that scenario. The reliance on this kind of survival performance may also stem from the women’s experiences of domestic violence and sex work. In those situations, a woman’s safety is dependent upon her ability to read and accurately respond to the moods, intentions and needs of someone else. A failure to guess correctly can have violent and disastrous consequences.

Part of the performance all users must engage in if they are to be given sympathy rather than censure (to be seen as a “heroin user” rather than a “smackhead”) is their public embrace of treatment. Returning to Kate Moss, after her cocaine scandal, part of her social rehabilitation was her rapid enrollment in drug rehabilitation. By giving herself up to a narrative of illness rather than debauchery, she was able to be “cured” and was
welcomed back into the fold.\textsuperscript{64} The performance of compliance is made more apparent when we consider that few people are ever “cured” of drug addiction in a single treatment episode, no matter how expensive the facility. After treatment Ms. Moss returned to the same life, friends, and milieu as before, a classic recipe for relapse. But what mattered, to the media and the fashion world, was that she had made a show of contrition. For the women in this study, engaging in treatment is the best means of communicating their contrition to those who matter. Showing up for appointments, even if they’ve “got a taxi waiting” puts a tick in the box for “in treatment” and earns points on the good-mother scale.

Stability may make the daily grind of mothering easier, but it does not make someone who has never been adequately parented understand how to do that for his or her own children. Many of the women in this study were abandoned by their parents either physically or emotionally and left to find their own ways of being in the world: Gina, whose parents didn’t acknowledge or stop the abuse by her grandfather, even when they knew it was going on; Zoe, whose family wouldn’t believe that her stepfather was abusing her until he abused someone outside their family; Mary, whose mother took the side of her abusive boyfriend against Mary; Laura, whose mother “went off the rails,” leaving her to the abuse of a string of the mother’s boyfriends, and whose father wouldn’t take her in when things got bad. These women all had a history of being let down by the people who should have protected them.

Drug treatment, as valuable as it may be, is only one element in a crowded landscape. Treatment lays the foundations on which other services can build, but it does

\textsuperscript{64} In a stunning (or perhaps cynical) bit of marketing genius, in 2011 Moss was hired to be the face of a Christian Dior cosmetics line named (unironically) \textit{Dior Addict}. 
not, in and of itself, transform the mother. It alone cannot address the other factors that influence parenting or environment. That is not to belittle stability. Overwhelmingly, the women themselves valued the stability that methadone gave them. It allowed them to feel normal without needing to resort to illegal drugs and the drudgery that procuring drugs entailed. It removed them from the network of illegal activities and unsavory characters that posed a threat to them and their children. It allowed them to focus on getting other aspects of their lives in order. Stability provided safety. But just as drug use does not automatically make them bad mothers, drug treatment will not automatically make them good ones. When we advocate for the availability of treatment for drug-using mothers, we must be aware of what, precisely, we hope to achieve with that treatment. Treatment replaces an illegal drug with a legal one. You are still “cotton wooled” or buffered against the real world. You are still “not all there.” Very few people, and no one in this three-year study, ever “finished” treatment. As Beverley said when I asked if she wanted help to cope with her post-pregnancy return to heroin use, “All they can do is put me on methadone, and I’m already on that.” Methadone maintenance is about achieving a kind of drugged stasis rather than getting clean. It effectively allows you to be high, just not too high.

Compliance is key. No matter what role she plays, a woman must follow someone else’s rules to achieve goals that may not necessarily be her own. While she wants to get her child back, she may not want the transformed life the service providers require of her. A break with drug-using friends and contentious families may count as a positive outcome for the service provider, but however transactional these friendships may have been, a break leaves the woman isolated and vulnerable when the official support
networks eventually fall away. Service providers – sympathetic, hardworking and dedicated though they typically are – may not realize that at times they are working at cross purposes with the women they are trying so hard to help. The huge numbers of support services attempting to get a woman back on her feet may knock her off them with their tidal wave of home visits, office appointments, directives and requirements. It is no wonder, then, that women, even while asking for help, simultaneously put up barriers to prevent being overwhelmed by the assistance. Circumspection with (or occasional avoidance of) services becomes the means by which women can assert some autonomy over their lives. From the perspective of the service providers, joined-up working is a circle of support coming together with united strength to support mothers. From the perspective of the mother, it is the Panopticon, monitoring her every action from every possible angle, 24 hours a day. If anyone can refer you to social services then everyone is a threat to your maternity.

**Fluid Motherhood**

For the women in this study, the battle for control was nowhere more contentious than in their fight for their right to mother. Women had to fight for control over their fertility, the custody of their children and their own claim to the role of “mother.” Partners fought with women over birth control or more children, women fought with the state over their right to mother, and family members fought with each other over who would get to mother the children placed “temporarily” in their care. For the women in this study, motherhood was not the automatic consequence of a full-term pregnancy, but rather, a fluid identity conferred, revoked and contested by a host of outside forces.

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65 With apologies to Adam Yauch.
Women tried to control their fertility with variable success. Younger women who had been on drugs for some time but had not previously been pregnant, thought they were physically unable to get pregnant. Heavy drug use, combined with environmental stressors like a lack of decent nutrition, made their bodies sub-fertile, but not infertile. Only when they were caught pregnant did they discover that their fertility had returned to normal. Older women who had already been caught were aware that they could get pregnant but faced other challenges when trying to control their fertility. New partners demanded new babies as love tokens, effectively marking their territory. Babies created a chain binding the mothers to their partners even as the men moved on to pursue other interests once the baby was born. As the father of her child, a man could continue to make demands of a woman (e.g., for shelter, companionship, money, etc.) that he would find harder to press with women who did not share his children. Recall that many of the mothers in this study, even those who had been beaten by their ex-partners, said they would never stop a father from seeing his children.

In trying to avoid this trap, some women, unable to control their partners, pursued fertility control through stealth means. Working the joined-up system to their advantage, they enlisted the professionals to keep their partners in the dark, or even just in another room, while they got the care they needed. Long-term injectable birth control gave them quick and invisible protection without risking the wrath of partners. Sterilization also proved a valuable tool for women whose previous attempts at control had failed. Sterilization offered them a chance to take control of an aspect of their lives that had been beyond their control for too long. It also reduced, though not eliminated, the number of
service providers who could cycle in and out of their lives. No more babies meant an escape from the intense period of scrutiny that is pregnancy.

From the moment they know they are pregnant until the day the child turns 16, the women in this study have to confront the possibility that at any moment someone could try to take their children away from them. While every mother has nightmares of losing her child to illness or accident, few have daily encounters with people who pose a palpable threat to their motherhood. Most non-drug-using women assume that they will be allowed to mother any child they bring to term. However, being a drug user, even a former user, marks women out for scrutiny and suspicion not experienced by non-users. The women in this study, even first-time mothers who maintained custody of their children, could not be entirely sure they might not eventually lose a child. Not having been well parented themselves, they had few positive experiential models to draw from. Instead, learning from their mistakes, women found each new baby was a new chance to get it right. In many ways the experience of the women’s own mothers was an exemplar of trial and error and heartache. The women whose mothers had custody of their grandchildren remarked on how much better the grandmothers now were at childrearing than they had been the first time around. Grandmothers who had “gone off the rails” when they were younger were now stable. Others, like Gina’s mother, had become better at giving emotional and practical support to their grandchildren than they were for their own children. While age and maturity may have had a great deal to do with the shift, it would be remarkable if the experience of witnessing their daughters’ struggles did not also invite a measure of self-reflection. For them, the grandchildren are a chance to make
amends for mistakes they may have made the first time around; their own cycle of trial and error, occasioned by heartbreak.

**Conspicuous, Latent and Abnegate Mothers**

The motherhood of the women in this study was in a constant state of flux. In order to make sense of this phenomenon, I have developed three descriptive categories of motherhood that I hope capture the shifts in meaning and experience for this population: The Conspicuous Mother, The Latent Mother and The Abnegate Mother. Building on the work of Kearney et al. (1995; 1994) on retaining a self-image as “mother” in the face of child loss, I hope to shed light on those women who, with multiple custody arrangements in their lives, do not fit neatly into dualistic classifications. The delineation of these categories is of necessity static, but it should be understood that, in reality, women travel within and among these categories over time and move among them as on a spectrum.

The Conspicuous Mother is one who is living with her children and engaging in the day-to-day activities of mothering, like feeding, clothing, and generally supervising the daily lives of her children. The conspicuous mother is what we ordinarily think of when we use the term “mother.” It does not refer to any of the cultural typologies of parenting (intensive, authoritarian, permissive, etc.). The conspicuous mother can be a good mother, a bad mother, or an indifferent mother, but she is indisputably “The Mother.” All of the women interviewed for this study fit into this category at some point. Each had actively cared for at least one of her children for at least some time, even if she was not currently doing so. When women were conspicuously mothering, they had the easiest time defining their mothering role to themselves and to others. They were clear
about their responsibilities toward their children. They were also more acutely aware of
moments when they fell short of their responsibilities as the conspicuous mother and of
the risks that their behavior posed to their ability to continue in their role as the
conspicuous mother.

Within the conspicuous mothering category there is also that of co-conspicuous
mothering. These are the instances typified by the grandmothering arrangements
mentioned above. Kristen and her mother are good examples of co-conspicuous
mothering. Though Kristen’s mother officially has custody of Kristen’s two older
children, Kristen and her youngest child (over whom Kristen has sole custody) all live
together in the same house. Kristen and her mother together are responsible for the
children’s upbringing. Though, in the eyes of the law, Kristen is not the children’s carer
any longer, from any practical standpoint, she still is. Should Kristen go off the rails and
leave her children to their grandmother’s sole care, the grandmother would remain the
conspicuous mother, whereas Kristen might begin the shift to a latent, or even abnegate
mother.

The Latent Mother is best exemplified by the woman who gives the quotidian
care of her child into someone else’s hands, but does not relinquish her emotional or
theoretical claim to be the mother of her child. She still very much considers herself to be
The Mother. Kristen herself fit into this category during the year when she was fighting
to regain custody of her youngest child, even while she was a co-conspicuous mother for
her older children. Emma, too, was a latent mother during those periods when she was in
prison and had to give over the care of her children to a family member. Emma knew she

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66 This is different from the ideology of intensive mothering described in the earlier chapters. That parenting ideology
assumes the mother occupies the conspicuous mothering role, but defines the role with behavioral prescriptives for
precisely how to actively and intensively mother.
would return to conspicuous mothering when she returned home, so she never relinquished the role of Mother. Yet latent mothering does not exist only in the short term. Rachel has a latent relationship with her three older children, who are being conspicuously mothered by their grandmother. Rachel loves them, tries to maintain contact with them and considers herself to be their mother, yet she feels they are better off where they are. The same could be said for Cathy, whose partner has custody of their older child. Though Cathy still feels herself to be his mother, she wants her son to remain in the relatively stable environment of his father’s house.

Conspicuous and latent mothering both allow a woman to retain her mothering identity and give her some sense of a stake in her children’s future. Abnegate mothering, on the other hand, is most akin to the experience of a child’s death, where the mother’s visceral memory of the child is all that remains of the mothering experience. Women who lose custody of their children with no hope of getting them back tend to fall into this category. Zoe, whose eldest daughter was adopted away at birth, says that she is not her daughter’s mother. She has no connection to her, no communication with her and no sense that she has contributed to her daughter’s life in any way, even while she grieves for her. This is in contrast to the conspicuous mothering she experiences with her two youngest boys and the latent mothering she experiences with her oldest son, who lives with his father. In the latter case, Zoe insists on drawing the distinction for her son between his father’s girlfriend and herself, wherein Zoe is the only one he may call “Mum.”

The difference between latent and abnegate mothering is largely experiential and subjective rather than a concrete external distinction. The woman described in the
previous chapter who saves copies of every letter she has ever sent to her absent child is more latent than abnegate. Gina, on the other hand, who is slowly renewing a relationship with her elder three daughters, says quite directly that she is not their mother because, she feels, she does not do the important mothering work of providing guidance and discipline. For Gina, the relationship she is developing with her daughters, while extremely valuable to her, is something she views as other than a mother-child one.

These categories are permeable, as the various examples above illustrate, with women occupying more than one at the same time or, in Zoe’s case, all three at the same time. Yet, it is for precisely this reason that I think these categories have utility. For these women, the term “mother,” as it is ordinarily applied, is insufficient.

It is possible that viewing mothering in this way may provide some insights into why some women relapse heavily after child-loss while others see child-loss as “rock bottom” and use the experience as an opportunity to change their lifestyles. The question is not which mothers “are” latent or abnegate, but what are the conditions that contribute to producing latent or abnegate mothers. Is it the degree of support from families or partners or state agencies that matters? Or is it past histories of trauma that contribute to feelings of powerlessness and thus lead some women to renounce the mothering role more quickly than others?

Debates about drug-using mothers fall broadly into two camps. One is “Isn’t it awful what these awful women are doing to their babies? Something must be done!” The other is “Isn’t it awful that these women have babies under these awful conditions? Something must be done!” The “something” proposed is then targeted toward fixing either the awful women or their awful conditions. Policies in the US are generally
modeled after the first camp, where the locus of the problem is situated within the woman herself. Solutions are centered on her body and on bringing that body under control, primarily through drug treatment and/or incarceration. By being punished, she is meant not only to serve as an example for others, but the punishment, it is assumed, will force her to confront and correct the error of her ways. It is a policy, built on a logic of self-determination, which privileges concepts of individual agency over structural inequality.

In contrast, policies in the UK acknowledge the larger environment as a powerful determining force, situating some of the locus of the problem outside of the woman’s own body. The focus on stability rather than on abstinence highlights this distinction. The provision of housing, welfare, and specialist midwives are all attempts to mitigate some of the damage done by an environment saturated with poverty, homelessness, and poor use of prenatal care. Yet these efforts, too, devolve into control over the woman’s body, as services are contingent on her compliance with drug treatment and attendance at countless appointments.

What is remarkable about the current study is that many of its findings are strikingly similar to those of studies conducted in North America and Australia over the past 20+ years: Drug-using women tend to come from difficult backgrounds; women strive to be good mothers but sometimes fail, and most significantly, the aspect of any policy that resonates most strongly for the women involved is the risk of child loss. For them, the difference in policy boils down to “You will lose your child” versus “You might lose your child.” This is true despite the widely different policy contexts of the earlier studies versus this UK-based study and the extensive provision of services available to the women in Manchester. Although there is much to be said for the added
value of ancillary services, it is clearly the woman’s fear of the potential removal of her child that occupies much of her energy. On both sides of the Atlantic the phrase “social services” is resonant with the threat of child loss. The child is the ultimate bargaining chip. Nonetheless, by using the child in this way, we make provisional the one relationship that should be everlasting. Women are expected to provide unconditional love to a child whose very presence in their lives is conditional. Drug-using mothers are criticized for supposedly violating the bonds of the mother-child relationship, but the bonds are already frayed by a system that forces them to confront the possibility of child loss before the child is even born. Women in this and other studies did indeed attempt to make changes “for the baby.” But as the women, particularly those with older children, made clear, those changes were often short-lived – not because they didn’t love their children enough, but because shit-life syndrome is a chronic condition. The child may have given them a boost in motivation, but it did not provide the long-term skill set necessary for them to dig themselves out of the shit.

At the same time there is, I think, a fear that any acknowledgment that a woman’s drug use may harm her children will lead to blanket policies of automatic child removal for all drug-using women. These fears are not unjustified. As we see from the enduring legacy of the crack baby epidemic, even scant evidence of harm can fuel massive efforts to incarcerate (mostly poor, mostly marginalized) women. Murphy and Rosenbaum’s excellent and ethnographically rich study (1999) of drug-using pregnant women challenges the reader to imagine how a woman who grew up in an environment dominated by poverty, abuse and chaos can be expected to overcome those environmental challenges simply because she falls pregnant. A fair point. But my
dilemma is this – if women who grew up in those circumstances ended up damaged, is it not equally likely that their children may end up similarly damaged when growing up in similarly damaging circumstances? In other words, we cannot blame women’s present circumstances on their horrible pasts and then ignore the effect that their still somewhat horrible presents may have on their children’s futures. To be clear, I am not saying that these women are inherently “bad mothers,” but I am saying that we must come to terms with the reality that their lives may replicate some of the damaging conditions of their own childhoods. Mothers in the study had spent time in prison away from their children. Mothers lived with violent partners who may have posed a risk to their children. Mothers moved home frequently, sometimes out of choice but more often out of necessity. Mothers were overwhelmingly poor and thus under the constraints and stressors occasioned by deprivation. Mothers did sometimes go “off the rails.” If we are to offer any real and lasting assistance to these women and their children, we must recognize that the mothers’ desire to be a good mother may not be enough.

So what is to be done? If the key is control, then how do we encourage and empower women to maintain control without simultaneously undermining their agency through dependency-inducing programming? Similarly, how do we provide services without threatening a woman’s right to mother, while still maintaining a duty of care and protection toward her children, who may, in some instances, be truly at risk?

One good example of an attempt at a solution is the Manchester Specialist Midwifery Service. It is an effective program that manages to be both empowering and non-threatening, but it is still very clearly the midwives’ responsibility to report suspected abuse or neglect. The service is empowering because it not only places the
responsibility for change in the hands of the women, but also involves them in deciding which changes are the most pressing at a given time. Rather than imposing a monolithic measure of “success” on the women, the service meets each woman where she is (both literally and figuratively) and guides her toward a mutually agreed-upon set of realistically achievable goals. Although the midwives are on the lookout for potentially troubling behaviors, the women and their partners whom I encountered in Manchester trust and respect the MSMS in a way they do not typically trust or respect other social services. This may be because the MSMS starts from the position of “What can we do to make sure you keep your baby?” rather than starting with “If you don’t do XYZ, I will have to take your baby.” The distinction is one of degree, but it is still important enough to alter the relationship between the women and the providers.

Yet the MSMS, while an excellent program, cannot provide a solution to the wider problems faced by drug-using mothers. Women who used the service were able to achieve a degree of stability and so retain custody of their children, but the MSMS does not have the capacity to alter the long-term socioeconomic conditions of these women and their children. In point of fact, the midwives have seen too many of their clients through multiple pregnancies, meaning that the changes they made were sufficient, but not transformative. Ultimately, the program gave women the ability to survive in their environment, but did little to change that environment.

The women in this study suffer not only from financial poverty but also from a poverty of aspiration. When women spoke of the benefits of drug treatment, they also spoke of the necessity of finding “something else to do” now that drug procurement was not taking up so much of their time. When discussing plans for their futures, only a very
few women expressed specific desires to be a drug counselor or a midwife – the two sets of people who they viewed as being the most valuable to them. More often, however, women spoke of wanting to go back to school but were unsure what returning to school might entail or to what it might eventually lead. Though they have a sense that “things could be better,” they have little idea of what “better” might realistically involve, or how to achieve it. “School” was a goal in and of itself, with little understanding of how one might parlay “school” into a job or career. Even those who wanted to be midwives did not realize the extent of additional schooling and training they would need to begin to pursue their goal. That is not to belittle their plans, or discount their abilities, but there is a need to acknowledge that many of these women are ill-prepared for the demands and criticisms of academic or professional life. Having used drugs as a primary coping strategy for years, they are in need of not just job skills, but also coping skills for the stressors of everyday life against which drugs had previously “cotton-wooled” them.

There is, frankly, a depressing sense of resignation to the status quo in the concepts of harm reduction and methadone maintenance. To maintain a dependence on methadone or merely reduce the harms of a lifestyle the women themselves see as damaging leaves little room for the pursuit of happiness. Instead, we must seek to develop programs that help prepare women to enter the “straight world” and help them learn to cope with the demands of that world once they get there.

A logical starting point would be to offer further education so that women can support themselves and their children without the need to depend solely on benefits. However, it is important to realize that merely training a woman to operate a press in a button factory may prove to be so unrewarding as to make her question the value of
leaving the flexibility of a career in the drug markets for the regimented and unrelenting monotony of the traditional market.

Instead, taking as its starting point women’s desire to go back to school, I propose a system of mentoring and sponsorship that will support women not just to enter school but to complete it and benefit from it. My idea is not new. In fact, I have adopted it, almost wholesale, from the model of the Posse Foundation in New York. This foundation takes “promising students from disadvantaged urban backgrounds” (i.e., smart but poor kids) and provides them with college scholarships. The foundation’s strength, however, is that it doesn’t simply send the kids off to school to sink or swim on their own. It works with a small number of universities and sends its scholarship students to those schools in a group or “posse.” Part of the idea is to use peer pressure to achieve a positive outcome. Posse students are given pre-university training on how to cope in school, then given a mentor within the school who meets with them regularly for the first two years of their time at the university. The posse of students is there to support one another through the entire collegiate process, and the foundation is there to support the posse. The program is amazingly effective, with its students achieving a 90% graduation rate67 (www.possefoundation.org).

A similar program could be very effective for drug-using mothers, though, unlike the Posse Foundation, which aims to recruit high academic achievers, the idea of this program would be to recruit women who are highly motivated to change the circumstances of their lives. Women interested in returning to school could be enrolled in the local university or adult education college in a group. The group would be

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67 The national average college completion rate in the US is 41%, according to The College Board. *The College Completion Agenda, 2011 Progress Report*. http://completionagenda.collegeboard.org/reports
accountable to each other and to the program for completing coursework, showing up to class, and remaining enrolled in the program. Rather than each woman trying to cope on her own, she would take all of her classes with the same group of women. The group would meet routinely with program staff to discuss problems or challenges as they occur and work to solve them before they become insurmountable. This would give women some protection from the isolation they face as drug-using mothers, and from the stigma they fear when interacting with non-drug using women. The program would also assist women in finding jobs when they complete their education, or in pursuing further degrees. Program alumni could then go on to be a valuable resource for one another and for up and coming classes of women. Just as the midwives and drug counselors have provided role models for women by treating them with both compassion and respect, women could take on that mantle for themselves.

Of course, mothers cannot be expected to join in any of these activities if they do not first have secure and reliable childcare. On the whole, women in this study had little respite from their children. Although there are a few daycare options for low-income women, they were not always appropriate for this population of mothers. Sure Start Children’s Centers, for example, offer low-cost childcare and ancillary health care and job training services, but were not well utilized by the women in this study. The centers are provided by the local government council and are open to anyone living in the surrounding area. As mentioned before, drug-using women tend to be fearful of associating with non-drug-using mothers and are wary of services that might pose a risk of child loss, like a government-operated childcare center. Women also had few drug-using friends whom they could trust to look after their children adequately. Some had
even unwittingly put their children at risk by leaving them with unsuitable carers (as was the case with Debbie, who lost custody of her children because someone she trusted abused them).

I propose then, a child-care collective. The collective would be staffed with a combination of professional educators and child carers but also with the mothers whose children are receiving care. The aim of the collective is two-fold, first, to provide the women with free childcare in a safe, non-judgmental environment where women are not fearful of being stigmatized by other mothers. Second, to help women learn some of the skills they may not have acquired from their own parents. Working alongside the professionals, women would be able to learn effective childcare strategies, like appropriate forms of discipline, while also demonstrating their own competencies in child rearing. Parenting classes which assume a universal level of ignorance and impose a uniform interpretation of “the right way” to parent may further undermine women’s sense of competency and authority. Instead, the professionals working alongside the women in the collective can see in what areas each woman excels and where she may need guidance. The women are thus given a combination of respite from and responsibility for children in an environment that values their experience and knowledge as mothers. The catch in the collective, though, is that women could not use the service without also working for it. Even if her shift is only one hour a week, a woman would be unable to use the service unless she was willing to invest her own time in helping other women get the same kinds of benefits she enjoys. This builds community among the women, ensures their continued engagement with the child care professionals and gives women a reintroduction to the routine of regular work they may someday be able to pursue. The
collective could also be used, like existing Sure Start Centers, as a site to identify any children in need of early intervention services for learning or physical disabilities and would provide a convenient place for children to receive those services. A similar program was used in Canberra, Australia, providing a non-judgmental playgroup for the children of drug-using mothers for 3-4 hours a week. In their study of the program Banwell, et al. (2002) found that women used the service not only because it offered activities for the children alongside health and advocacy for the mothers, but also because use of the service did not pose a threat to the custody of their children (Banwell and Bammer 2006; Banwell, et al. 2002).

Crucially, in neither the school program nor the childcare collective would participation be a prerequisite for retaining custody of children. The programs are beneficial to women in and of themselves and can be used singly or in combination depending on the women’s needs at a given time. Like the MSMS, the “penalty” for non-participation is the loss of the program’s benefits rather than a loss of children. And like the MSMS, the support structure is there to empower women to take action for themselves, not to override women’s actions with an externally driven agenda. But unlike MSMS, the programs are also about moving beyond the prenatal period to create real, sustainable change in women’s lives and those of their children. The programs seek to combat some of the problems women identified throughout the study, like feeling isolated, feeling ill-prepared for “straight” life, and feeling that much of their lives were out of control. These suggestions are not meant as an exhaustive list of options but rather serve as examples of the kinds of work that could be done to foster women’s

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68 Sure Start Centers provide a range of childcare, health and advocacy services to low-income women and children, but because they are open to “straight” women, the women in this study were not always comfortable engaging with them.
independence while simultaneously improving their and their children’s lives. The women in this study have time and again proven themselves to be survivors. But survival alone should not be the goal. It is just a starting point.

**Further research**

For my own part, I wish I had found an opportunity during this research to engage more meaningfully with the grandmothers. Their experiences of parenting their grandchildren while still coping with their child’s drug use would go some way towards squaring the circle of familial patterns of drug use. Knowledge of their experiences might also give some insight into what prompted the shift to stability for women who had been “chaotic” when their children were younger but had since made sustainable changes. If we knew what had changed for them, there would potentially be an opportunity to effect that change sooner for the next generation.

Although most studies of drug use focus on men, much of the research into drug-using parents has tended to focus on women. Future work could do far more to explore the parenting experiences of drug-using men. Those few men interviewed alongside the women in this study provided glimpses into the kinds of issues male drug users struggle with when they become parents, such as the motivation to become fathers, the custody of children when mothers are in jail or in residential treatment, and the lack of awareness of men’s parenting roles among service providers. Importantly, there is a small but growing body of research with the children of drug-using parents to uncover the issues that most affect them. Still more needs to be done to explore the intersection of drug use and
parenting from a perspective that once and for all eschews the fallacy that drug use inevitably leads to neglect.
Bibliography

Adams, M., and J. Raisborough
Advisory Council on the Misuse of Drugs
Armstrong, E. M.
Ashley, O. S., M. E. Marsden, and T. M. Brady
Atkinson, P.
Backett-Milburn, K., et al.
Balshem, M., et al.
Bandstra, E. S., et al.
Banwell, C., and G. Bammer
Banwell, C., B. Denton, and G. Bammer
Barker, K. K.
BBC.co.uk
2002 Could Victoria have been saved? In BBC News. BBC News London: bbc.co.uk
Behnke, M., et al.
Behnke, Marylou, et al.
Bendersky, M., D. Bennett, and M. Lewis
Berghella, V., et al.
Bliss
Boyd, S. C.
1999 Mothers and Illicit Drugs: Transcending the Myths. Toronto: University of Toronto Press.
Bridges, K. M.
Broad, B.
Brown, H. L., et al.
Burgess, C., et al.
Bushman, R. L., and C. L. Bushman
Campbell, N. D.
Center for Reproductive Law and Policy
Chasnoff, I. J., et al.


Dashe, J. S., et al.

Davenport-Hines, R. P. T.

Degenhardt, L., et al.

Degenhardt, Louisa, et al.
2010 Evaluating the drug use gateway theory using cross-national data: Consistency and associations of the order of initiation of drug use among participants in the WHO World Mental Health Surveys. Drug and Alcohol Dependence 108(1):84.

Department for Communities and Local Government

Doberczak, T. M., S. R. Kandall, and P. Friedmann

Douglas, S. J., and M. W. Michaels

Dryden, C., et al.

Ehrenreich, B., and D. English
1978 For her own good: 150 years of the experts' advice to women. Garden City, N.Y.: Anchor Press.

Ellgren, M., S.M. Spano, and Y.L. Hurd

Flavin, J., and L. M. Paltrow

Foucault, M.

Frank, D. A., et al.

Frank, D. A., et al.

Frost, J. J., J. E. Darroch, and L. Remez

Fullilove, M. T., et al.

Fullilove, M. T., E. A. Lown, and R. E. Fullilove

Gilman, C. P.

Glaser, B. G., and A. L. Strauss

Goffman, E.

Gossop, M., J. Marsden, and D. Stewart

Gregory, J.

Hall, W., and M. Lynskey

Hamdan, A.H.

Hanson, C.

Hays, S.

Hepburn, M.

Holt, S., H. Buckley, and S. Whelan

Home Office

Hooper, C. A., and C. Humphreys
Human Rights Watch
Hyman, S. M., et al.
2008  Severity of childhood trauma is predictive of cocaine relapse outcomes in women but not men. Drug and Alcohol Dependence 92(1-3):208-216.
Jansson, Lauren M., and Martha Velez
Johnston, D. D., and D. H. Swanson
2006  Constructing the "good mother": The experience of mothering ideologies by work status. Sex Roles 54(7-8):509-519.
Kandel, D.
Kantor, G. K., and L. Little
Kearney, M. H., et al.
Kearney, M. H., S. Murphy, and M. Rosenbaum
Klee, H., M. Jackson, and S. Lewis
Klein, D., and E. Zahnd
Knight, D. K., S. M. Logan, and D. D. Simpson
Koenig, B.A.
Kopels, S., and M. C. Sheridan
Landsman, G. H.
Lawless, S., S. Kippax, and J. Crawford


McIntosh, James, and Neil McKeeganey 2000 Addicts' narratives of recovery from drug use: constructing a non-addict identity. Social Science & Medicine 50(10):1501-1510.


Murphy, S., and M Rosenbaum

Oakley, A.

Oaks, L.

Ornoy, A., et al.

Ornoy, A., et al.

Paltrow, L.

Paltrow, L. M.

Paone, D., et al.

Parsons, T.

Penfold, C., P. J. Turnbull, and R. Webster

Petchesky, R. P.

Powis, B., et al.

Rhodes, T., S. Bernays, and K. Houmoller

Rhodes, T., and L. Cusick

Rhodes, T., et al.

Rich, A.

Richter, K. P., and G. Bammer

Rose-Jacobs, R., et al.

Rosenbaum, M.

Roy, J., et al.

Sales, P., and S. Murphy

Schoen, J.

Schunmann, C., and A. Glasier

Simmonds, J.

Simpson, T. L., and W. R. Miller

Sinclair, I.

Small, D.
2001 The war on drugs is a war on racial justice. Social Research 68(3):896-903.

Smart, C.

South Manchester University Hospitals NHS Trust

Springer, K. W.
Starr, P.
Street, K., et al.
Sun, AnPyng
Taylor, A.
New York: Clarendon Press ;
Oxford University Press.
Thajam, D., et al.
Theriot, N. M.
Thomas, S. S.
Thornton, T. E., and L. Paltrow
Tsing, A. L.
Vogel, G.
Volpe, J. J.
Vulnerable Children's Service
Walby, S., and J. Allen
Walkinshaw, S., B. Shaw, and C. Siney
Watts, R.
Weaver, T., et al.
Widom, C. S., S. J. Czaia, and M. A. Dutton
Widom, C. S., N. R. Marmorstein, and H. R. White
Zola, Irving Kenneth