MOTHERS AND ILLICIT DRUGS:
TRANSCENDING THE MYTHS

by

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M.A., Antioch University, 1984

THESIS SUBMITTED IN PARTIAL FULFILMENT OF
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of
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Title of Thesis/Project/Extended Essay
Mothers and illicit drug use: Transcending the Myths

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ABSTRACT

This study provides a critical feminist analysis of qualitative data regarding women who use illicit narcotics in Western Canada, focusing on their opinions regarding the law and medical and social service policy and regulations that affect their lives. Specifically, this research brings forward the views of 28 mothers who have used illicit drugs. Their views concerning medical treatment for adult women and their newborn infants, Canadian narcotics laws and the effects of treatments are presented. The study also includes data on the role of social services in relation to intervention and to the apprehension of children.

This study reveals the diverse nature of women who use illicit drugs. The consequences of their illicit drug use were mediated by social status, race, class, gender and social environment, as well as by the law, social services and the medical community. Aside from their status as mothers and their use of illicit drugs, the women interviewed were not homogeneous.

This thesis also illustrates how the identification and diagnosis of Neonatal Abstinence Syndrome (NAS) is mediated by mothers' race and class. The label NAS is a cultural construct that serves the medical, social services and legal professions through increased social control of women. "High-risk" attributions and legal, medical and social service interventions serve to separate families and to stigmatize and
punish both infant and mother.

The importance of ideologies in shaping drug legislation, policy and practices, particularly in the areas of justice and familial ideology is explored. By linking the research on reproductive autonomy and mothering with a critical analysis of drug use within a historical context, this thesis reveals the social control of women who use illicit drugs against a backdrop of the social control of non-drug using women in Western society. Current social attitudes and subsequent harmful practices such as the erosion of civil liberties of mothers and infants flow directly from the criminalization of specific drugs and the social fictions that separate "good" and "bad" drugs. Social attitudes towards mothers who use illicit drugs have implications for all women, though First Nations and poor women are over-represented in terms of medical intervention, arrest and child apprehension.
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CHAPTER 1 - The Research Objectives

I. INTRODUCTION

Since the criminalization of drugs in the early twentieth century, there has been a proliferation of research concerning illicit drug use in Western society. However, the majority of this research describes illicit drug use by males, and women are rarely included in research designs. When included, women have been predominantly discussed as immature, sexually promiscuous, immoral, pathological, and more deviant than men (see Inciardi, Lockwood, & Pottieger, 1993; Stevenson, Lingley, Trasov, & Stansfield, 1956). Illicit drug use is deemed incompatible with sexual virtue, mothering and family values. These are the cultural values women are supposed to embody and protect in North America (Rosenbaum, Murphy, Irwin, & Watson, 1990, p. 2).

Critical researchers, who emerged in the 1960s, transformed the study of illicit drug use. The movement from perceiving the "addict" as a criminal to examining how legal and social definitions define the illicit drug user both symbolically and directly stems from their research. Consequently, the impact of the law, morality and race and class informed their research on illicit drug use, and the social construction of the line dividing licit and illicit use was revealed.

Nevertheless, little information is available that analyzes the social and economic environment of women, and
early critical research did not include a gender analysis. However, by the 1970s the impact of feminism began to inform social science research pertaining to the role of pharmaceutical companies and their gendered prescribing of legal drugs. In addition, the first ethnographic study on women heroin users was published in 1981 (Rosenbaum, 1981).

Since the 1980s, social science research has moved from a concern about female illicit drug users to a concern about the developing fetuses of women who use illicit drugs. Maternal drug use, assessment of risk and the treatment, identification, regulation and control of wayward mothers have become central to conservative and liberal research on illicit drug use. However, neither conservative nor liberal paradigms offer solutions for underlying problems associated with class, gender and race. In addition, the negative impact of the medical and social service professions and of drug legislation on women who use illicit drugs is ignored.

The majority of social science research concerning maternal drug use has emerged from the USA, where legal sanctions pertaining to prenatal exposure to illicit drugs have been put in place. In addition, social science research exploring prenatal programs and maternal care in Europe has transformed the discussion of maternal drug use. European studies illuminate the differences between research findings in the USA and in countries that have different socioeconomic environments and different drug legislation.
The Research Study: A view of women who use illicit drugs

To date there is no information in Canada about how mothers who use illicit drugs view the agencies of law, social services and the medical profession. Nor has there been any critique by mothers of the services provided to them and their children. This research provides qualitative data regarding women who use illicit narcotics in Canada, focusing on their opinions regarding the law, medical and social service policy and regulations that affect their lives. It also provides a feminist analysis\(^1\) of the literature and explores society's attitudes toward mothers and illicit drug use. Specifically, it brings forward the opinions of mothers who use illicit drugs concerning the medical treatment of adult women and their newborn infants, Canadian narcotics laws and the effects of treatments, in addition to providing data on the role of social services in relation to intervention and to the apprehension of children.

**An Integrative Approach**

The tradition of using sociological ethnography and profiles of "criminal careers" in describing illicit narcotic use tends to separate the researched from the researcher and ultimately to separate the researched from society. The

\(^1\) A feminist analysis and perspective is theory culminating in practice that places women in the centre of discourse, emphasizing "the importance of sex, race and class as factors which together determine the social construction of femaleness" (hooks, 1989, p. 23). See Chapter 5 of this study, "From Theory to Method" for a more thorough discussion of feminist analysis and perspective.
"deviant" stereotype remains entrenched in the late twentieth century, rather than diminished (Liazos, 1972). Attempts to categorise and separate women who come to the attention of social services, the medical profession and the criminal justice system from conventional society disregard the near universality of drug use and the diversity of illicit drug users. Categorization of this kind encourages one to see certain groups of people as Other. However, it is not just women who use illicit drugs who are regulated by the law, medicine and social services. According to Smart and Smart (1978) all women experience social control in relation to their reproductive cycle, double standards of morality, social and legal subordination, the separation of private and public spheres, and the ideology\(^2\) of a woman's place as the private sphere (p. 3). Socio-economic environment, law, and class, gender and race mediate one's own experience of illicit drug use. The effects of illicit drugs themselves are quite benign compared to the legal, medical and social service control of their use, and the stereotypes that inform these professions.

This research attempts to discuss the lives and opinions of women who use illicit drugs against the background of the social control of women in Western society. Women who use

\(^2\) "Ideology is dialectically related to the nature of social relations and serves not to distort or hide that relationship but to reify class differences as intrinsic and natural (Harvey, 1990, p. 24). "ideology serves to conceal contradictions and it is ideology that renders myths natural" (Harvey, 1990, p. 198).
illicit drugs have been subject to specific forms of social control deriving from their role as mothers. Apprehension of children, arrest, detainment, forced medical treatment and monitoring of women who are suspected of having used illicit narcotics, prior to and during pregnancy and postnatally, have occurred in North America. Feminists perceive this phenomenon as violence against women and further curtailment of women's reproductive autonomy.

This study examines how the legal, medical and social service professions construct illicit narcotics use in relation to mothering and the criminalization of pregnancy, and how drug laws have infringed on the human rights of women in Canada. The expansion of state control of narcotic users is analyzed in relation to ideological struggles, social control, reproductive autonomy and control of states of consciousness (the state determining which drugs, and drug experiences, are legal). This research has necessitated an integrative approach that applies a critical feminist framework to several disciplines including the law, medicine, sociology and history.

The orientation of this study is interdisciplinary, providing a forum for the women interviewed, and presenting analyses of the ideological struggles involved and of the subsequent harms and human rights infringements.

In order to understand illicit drug use and women's struggles for reproductive autonomy in Canada it is necessary
to place these discussions within a historical context. This research will provide condensed outlines of the histories of drug use and reproductive autonomy in order to facilitate the discussion of the current phenomenon of women who use illicit drugs. This thesis does not attempt to examine or analyze all historical accounts of drug use and reproductive autonomy in Canada. Rather, it aims to integrate both sets of literature and to draw from selected historical research in order to provide a social and political context in which to place the data.

The majority of women and men who use illegal drugs in our society are occasional users and we have much to learn from their relationship with drugs. This study will not include interviews with occasional users of illicit drugs, though all discussion of drug use will emphasize the "continuum of involvement" developed by Alexander (1990). Contrary to the popularized image of the addict needing more and more drugs to get high, many users stabilize their use and many discontinue use. This research will highlight individual differences in drug use. Finally, in this study only mothers were included in the core interviews.

The Benefits of the Research

The birth of the human sciences in the 19th century brought new knowledges that sought to discipline and normalize society (Foucault, 1980). The human sciences have contributed to the emergence of knowledge concerning disease conceptions
of addiction, treatment and recovery which seek to regulate and control individuals who use illicit and licit drugs.

Currently, illicit drug use is perceived as deviant behaviour and the selective criminalization of women who use illicit drugs in North America is obscured by the use of labels such as "addict" and "drug baby." Alexander (1990) notes that the word addict has only recently developed as a negative label reserved for illicit drug users. Imprecise definitions and language have resulted in misleading information about people who use both legal and illegal drugs (Alexander, 1990, pp. 102,103). This dissertation will attempt to demystify the labels applied to women who use illicit drugs, for as Faith (1993) states:

when we recognize the contextual bases of illegal actions and the discriminatory nature of criminalization processes as applied to either men or women, and when we demystify labelled women by showing their diversities as well as the commonalities they share as women in a gendered power structure, we lose the need for labels, or for gendered stereotypes (p. 59).

Overall, this research contributes to a framework for further feminist inquiry into the expanding network of control of female illicit drug users, mothering and reproductive autonomy. The expansion of state control of illicit narcotic users is analyzed in relation to the ideological struggles surrounding the social control of women, reproductive autonomy, human rights and control of states of consciousness.
The research aims

The research explores social attitudes toward illicit drug use, women and illicit drug use, and mothering and illicit drug use. Its aims are:

1. To apply a feminist analysis (an analysis of race, class and gender) to explore the literature and explore social attitudes toward illicit drug use, and more specifically toward mothers who use illicit drugs in Canada.

2. To link the research on reproductive autonomy and mothering with critical analysis of drug use within a historical context.

3. To examine how the legal, medical and social service professions regulate and punish women, and more specifically how they affect mothers who use illicit drugs. In addition, the concepts resistance and agency will be explored.

4. To compare treatment models and services available to mothers who use illicit drugs, and their infants, in Canada, The Netherlands, England and Scotland.

5. To examine the infringement on human rights incurred by the criminalization of drug use.

The Organization of the Thesis

The following chapters will seek to demonstrate how mothers who use illicit drugs are regulated through formal and informal social controls. Women are regulated and punished when they come into contact with medical and social service
professionals outside of the criminal justice system. The data chapters present the research findings on the views of the women interviewed in relation to the medical and social service professions, and drug treatment services. Chapter ten presents research findings on formal social controls through the criminalization of specific drugs. The final chapter presents a summary of the thesis and policy directions.
CHAPTER 2 - Literature Review and Theoretical Framework: Part One

Introduction

The emergence and contributions of the critical perspective, which has challenged traditional beliefs about illicit and licit drugs, is explored in this chapter. This chapter examines the pharmacology of drugs and question the traditional view that specific drugs are inherently dangerous. In addition, the criminalization of certain drugs in Canada is discussed within a historical context. In conclusion, the pharmaceutical industry, drug treatment, alternatives, decriminalization and legalization and the concept of social control are explored.

I. THE SOCIAL CONSTRUCTION OF "GOOD" AND "BAD" DRUGS

There is probably one thing, and one thing only, on which the leaders of all modern states agree; on which Catholics, Protestants, Jews, Mohammedans and atheists agree; on which Democrats, Republicans, Socialists, Communists, Liberals, and Conservatives agree; on which medical and scientific authorities throughout the world agree; and on which the views, as expressed through opinion polls and voting records of the large majority of individuals in all civilized countries agree. That thing is the "scientific fact" that certain substances which people like to ingest or inject are "dangerous" both to those who use them and to others; and that their use of such substances constitutes "drug abuse" or "drug addiction" - a disease whose control and eradication are the duty of the combined forces of the medical profession and the state. (Szasz, 1974, p.ix)

Though many "experts" agree with political leaders that drugs are "dangerous," there is no consensus about which drugs are dangerous. In Canadian society, alcohol and tobacco use are
tolerated; in Muslim countries, alcohol is banned and opiates are tolerated. Attitudes about which drugs are good or bad change over time. Prior to 1911, opiate use was accepted in Canadian culture; today we no longer tolerate the nonmedical use of "narcotics". Instead, we have prohibited narcotic use—it is now a criminal offence to use, sell or buy narcotics unless they are prescribed by a physician.

Following the criminalization of narcotics in Canada, illicit drug use was predominantly constructed as a legal and/or medical problem. The legal model constructed the "addict" as a criminal, and the medical model embraced the "addiction as disease" philosophy. Both the legal and medical models view illicit drug use from a narrow, individualized framework. Both the medical and criminal models of drug use frame policy affecting, and treatment of, women who use illicit drugs during pregnancy. Traditional beliefs about the harmful effects of narcotic include the following:

1. Young people are lured into the use of drugs by unscrupulous traffickers.
2. Once addicted, the drug user loses all moral sense.

3Opium (Papaver somniferum) is the parent of all narcotics, a gummy substance extracted from the opium poppy. Opiates are drugs that have both sedative and analgesic actions. Heroin, morphine and codeine derive from the opium poppy.

4"The Narcotic Control Act declares that marijuana, cocaine, heroin, PCP, and a number of other lesser known drugs are "narcotics". However, the pharmacological definition of "narcotics" is "a class of depressant drugs derived from opium or related chemically to compounds in opium" (Weil & Rosen, 1993, p. 224).
3. One becomes a dangerous criminal due to one's drug use.
4. The drug user becomes dangerous and crazed when under the influence of drugs or when experiencing withdrawal.
5. The drug user's physical health will deteriorate.
6. The drug user's mind will be permanently damaged (Stevenson et al., 1956, p. 507).

Although the harmful effects listed here have not been scientifically proven, these assumptions still underlie much contemporary research about drugs. The impact of drug laws, the socio-economic environment, and the role of race, class and gender were not considered, outside of blaming specific ethnic minorities for contributing to illicit drug use and luring middle-class women into a life of sin (see Murphy, 1922). The following section examines the social construction of "good" and "bad" drugs, set and setting, and opium and coca derivatives. Rather than attempting to present an overview of all drugs, the discussion focuses on the dangerousness and harm of specific drugs and the underlying rationale for criminalizing the use and possession of drugs. Narcotics (opium derivatives), cocaine, prescription drugs, alcohol and tobacco are examined in relation to the harm they cause.

Determining what is a drug can be complex. Traditionally drugs have been defined as "any substance that in small amounts produces significant changes in the body, mind, or both" (Weil & Rosen, 1993, p. 9). However, Weil and Rosen (1993) point out how this definition may apply to food and poisons as well. In addition, psychoactive drugs - those
substances that alter "mood, perception, and thought" - are difficult to categorize. For example, Weil and Rosen note how difficult it is to categorize alcohol, which can be considered a food, a drug or a poison.

Drug use is universal. However, drugs have been categorized as good or bad through legal sanctions. Attitudes surrounding drug use are not static. Until 1908, narcotics were licit substances in Canada. Furthermore, although it is currently legal to ingest alcohol in the U.S., alcohol was prohibited for a short period of time after World War I (1919-1933). The classification of drugs as licit or illicit is not straightforward. As we will see, such licit drugs as alcohol and tobacco are more dangerous to health than illicit drugs.

Weil and Rosen (1993) suggest that drug-taking may be a basic human activity. Changing consciousness can take many forms, of which drug use is only one. It appears that even young children wish to change their consciousness, as is evident in their play when they twirl, spin and tumble. Furthermore, pharmacology may not be as important as "set and setting," a concept first introduced by Timothy Leary. Weil states:

Set is a person's expectations of what a drug will do to him, considered in the context of his whole personality. Setting is the environment, both physical and social, in which a drug is taken (Weil, 1972, p. 29).

Set can be more important than the pharmacology of a drug in shaping a user's long-term relationship with a particular
Drug, and setting can modify pharmacology (Weil, 1993). Zinberg and Harding (1979) suggest that the low recidivism rates for Vietnam veterans addicted to smoking heroin during the war were due to set and setting. Smoking heroin was culturally acceptable in Vietnam and veterans found the social setting of Vietnam to be "both alien and extremely stressful" (Zinberg & Harding, 1979, p. 179). This was a significant factor in influencing veterans who normally would not have used heroin to begin using it. Social factors can influence the effects of drugs. People form relationships with specific drugs, and these relationships may be healthy or unhealthy. In addition, individuals react differently to similar drugs and dosages.

Drugs can be taken in many different forms. They can be taken orally, absorbed through inhalation (smoking), administered through the mucous membranes of the mouth or nose (sniffing) or administered by injection, either intravenous or subcutaneous. The route one chooses may shape one's relationship with his or her drug of choice. For example, chewing coca leaves is different from injecting cocaine. It may be more difficult to form healthy relationships with more concentrated drugs.

Psychoactive drugs are classified as either natural, refined, semisynthetic or synthetic. Natural or organic drugs, which come from plants, consist of complex mixtures which contribute to the effect of the drug. For example, the coca
leaf contains 14 drugs, cocaine being only one of them. The other drugs in coca often appear to modify the stimulating effect of cocaine. Coca leaves also contain vitamins and minerals (Weil & Rosen, 1993, p. 44). Organic drugs seem generally to be less toxic than synthetic drugs, and have less potential for abuse (Weil & Rosen, 1993). Isolating active principles from drug plants and creating synthetic drugs has led to the emergence of a pharmaceutical industry interested in more potent and purer drugs that may have more potential for abuse. It appears that synthetic drugs made in laboratories (e.g., Valium) may be the most difficult ones with which to form good relationships. Weil and Rosen (1993) note the difference between chewing coca leaves and injecting cocaine. The coca leaf rarely contains more than 0.5 percent cocaine (Weil & Rosen, 1993, p. 31). In contrast, refined cocaine can be 100 percent pure (Weil & Rosen, 1993, p. 31). However, the use of organic plants, rather than refined and pure drugs, is perceived as "unscientific" (Weil & Rosen, 1993). In addition, organic drugs such as marijuana, opium and cocaine are described in Western society as "bad drugs" originating from developing third-world countries (Boyd, 1991).

**Cocaine**

The coca plant has grown in South America for thousands of years (Alexander, 1990; Weil & Rosen, 1993). As mentioned above, cocaine is isolated from the coca leaf. The coca leaf
is still used by millions of indigenous peoples in South America as a stimulant and medicine. Traditionally, one chews the coca leaf, swallows the juices, and spits out the leaves. By the late 1800s the use of coca in tonics and wine became popular in Europe and North America (Weil & Rosen, 1993). Cocaine was isolated from the coca leaf during this time and used as the first local anaesthetic. Doctors prescribed cocaine for many medical problems. It was not until the 1900s that the use of coca and cocaine was criminalized in Canada.

Since the 1980s, the media and medical literature have reported an increase in cocaine use in the preparation of crack, which is simply cocaine powder cooked in a bicarbonate of soda solution (Cheung, Erickson, & Landau, 1991; Waldorf, Reinarman, & Murphy, 1991). Crack has been described as the most addictive drug on earth. Crack addiction is purported to have reached epidemic levels. Crack is said to have a "disinhibiting and degrading effect" on people (Inciardi et al., 1993, p. 71) and to produce a "release of normal inhibitions on behavior, including sexual behavior" (Inciardi et al., 1993, p. 96). However, early research demonstrates that casual use of cocaine (not including its use in the form of crack) is the norm (Waldorf et al., 1977; Reinarman, 1979). Later research has noted that 20 percent of the men and women in a Canadian study reported "uncontrollable" urges to continue using cocaine after ingestion on some occasions;
however, controlled use continued to be recognized as the norm (Erickson, Adalf, Murray, & Smart, 1987, p. 107).

Cocaine users (including crack users) employ a host of strategies to monitor their drug use. Consequently "the desire for cocaine did not overpower users' concerns with family, health, and careers" (Waldorf et al., 1991, p. 261). Cheung, Erickson, and Landau (1991) note that crack use is not "necessarily compulsive" and that perceptions of "risk of harm" shape individuals' patterns of use. In addition, unlike many U.S. studies of crack use (see Inciardi et al., 1993), a Canadian study of "moderate crack users" demonstrates that crack users are similar to users of powder cocaine with respect to sociodemographic characteristics (Cheung, Erickson, & Landau, 1991).

After reviewing the literature on cocaine, Alexander (1990) notes that cocaine is no more addicting than many other drugs and that there is no cocaine epidemic in Canada. Alexander and his colleagues have more recently demonstrated in their British Columbia study of recreational and addicted cocaine users that crack is not "instantly addicting." They have also shown that cocaine use does not lead to a deviant and dangerous lifestyle (Matthews, Dawes, Nadeau, Wong, & Alexander, 1995). People have a wide range of responses to cocaine use and there is no uniform progression of use. The majority of cocaine users are successful in maintaining unproblematic and controlled use (Waldorf et al., 1991).
Opium Derivatives

Opium (Papaver somniferum) is the parent of all narcotics, a gummy substance extracted from the opium poppy. Opium is one of our oldest drugs; it was used in prehistoric times and by the ancient Greeks (Weil & Rosen, 1993). Most narcotics are chemically "classed as alkaloid, ring-shaped organic compounds known for their bitter taste" (Alexander, 1990, p. 131). Narcotics are carried in the blood to the brain, where psychological effects occur. It does not matter how the drug is taken; the effects are the same, "although the route of administration affects the speed of action and the amount that is required to produce a given effect" (Alexander, 1990, p. 131).

Opium can be taken orally, in solid or liquid form, or smoked. Opium contains 20 different drugs, the most important of which is morphine. Morphine was isolated from opium in 1803; this was the first time an active ingredient was isolated from a drug plant (Weil & Rosen, 1993; Trebach, 1982). Codeine (methylmorphine) is another active ingredient of opium that can be isolated and extracted. Codeine is usually taken orally, in pill form, and is a popular and widely used drug for moderate pain.

Discovered in 1898, heroin (diacetylmorphine) is produced by heating morphine with acetic acid, and is a semisynthetic drug which converts to morphine in the body (Brecher & The Editors of Consumer Reports, 1972). Heroin and morphine can be
smoked, sniffed or injected. It has been argued in the past that heroin has the greatest abuse potential of all the opiates; however, that argument has been successfully challenged (Weil & Rosen, 1993; Trebach, 1982; Brecher et al., 1972).

Synthetic narcotics include Demerol (meperidine) and methadone (dolophine). These drugs are not derived from opium but have similar effects. With the growth of pharmaceutical companies in this century, the list of synthetic narcotics has grown. Percocet, Percodan, and Darvon are also synthetic narcotics. Since the mid-nineteenth century there has been a shift in use from organic narcotics to the synthetic ones. One of the reasons for this shift is that organic narcotics cannot be patented (Lexchin, 1984) and pharmaceutical companies are interested in profit and new markets.

Narcotics are commonly used to relieve pain, to suppress coughing, to relieve diarrhea, and to induce sleep (Biernacki, 1986; Weil & Rosen, 1993). Physical side effects may include drowsiness, constipation, decreased sexual libido, sweating, depressed breathing and menstrual irregularities (Alexander, 1990, p. 147; Brecher et al., 1972; Stevenson et al., 1956). Contrary to social science literature and media reports that describe the horrors of narcotic addiction, there is no organic deterioration or known permanent damage due to the use of narcotics. All side effects cease when use is discontinued.
Death may occur in very rare instances (Alexander, 1990; Brecher et al., 1972). Until recently, there were about 100 narcotic-related deaths each year in Canada (Boyd, 1991, p. 224). There were 422 drug-related deaths in Canada in 1990 (Single, Williams & McKenzie, 1994, p. 110). However, it is impossible to determine exactly how many deaths are attributable to illicit drugs in Canada, as Canadian hospitals do not distinguish between illicit and licit drugs when coding problems due to usage of drugs (Single et al., 1994, p. 108). Recently, in British Columbia, there has been an increase of deaths from drug overdose, from 39 in 1988 to 331 in 1993 (Cain, 1994, p. 5). However, it is not clear that all these deaths are related to narcotics overdoses. Brecher argues that many of the statistics in the U.S. falsely label death as due to narcotic overdose (Brecher et al., 1972, p. 104). Additionally, Wong and Alexander (1991) have noted that "cocaine-related" deaths have also been misrepresented by the press.

The recent Coroner's report on the increase in narcotics overdoses in British Columbia noted that over 55 percent of the individuals whose deaths were attributed to overdose were legally impaired due to ethanol (alcohol) (Cain, 1994, p. 12). Therefore, the label "heroin overdose" is generally incorrect; often many other drugs, and particularly licit drugs, have
been taken along with heroin--alcohol being the primary drug used in conjunction with heroin in British Columbia. The Coroner’s report noted that in two-thirds of the reported overdose deaths the victim used more than one drug (Cain, 1994, p. 12).

Furthermore, deaths due to licit drug use outnumber those due to illicit drug use. Canada has about 35,000 tobacco-related deaths a year, and there are an estimated 3,000 to 15,000 alcohol-related deaths every year (Boyd, 1991, p. 224; Single et al., 1994, p. 23,89). Alcohol and tobacco, our most poisonous drugs, are legal in Canada (Alexander, 1990; Boyd, 1991; Single et al., 1994).

Contrary to reports of instant addiction, not all narcotic users become addicted. In reality, many people use narcotics for years on an occasional basis without becoming addicted (Biernacki, 1986; Blackwell, 1983; Trebach, 1982). Many people have used medically prescribed narcotics without becoming addicted (Trebach, 1982). If narcotics are used daily over an extended period of time (months), dependence may occur. However, many narcotic users do not increase their use over time; many decrease use, and some stabilize their narcotic use (Alexander, 1990; Biernacki, 1986, Blackwell, 1983; Trebach, 1982).

Physiological dependence on narcotics may cause withdrawal symptoms when use is ceased. However, withdrawal symptoms vary from person to person, regardless of the amount
of narcotics used prior to cessation (Alexander, 1990; Boyd, 1991). Some users have no withdrawal symptoms; some experience mild flu-like symptoms; some experience severe flu-like symptoms. The wide range of experience suggests that psychological factors, rather than the drug, may determine the severity or mildness of withdrawal. If withdrawal symptoms do occur, many drugs are available to relieve the symptoms (Alexander, 1990, p. 148).

During the nineteenth century, Canadian and European medicine cabinets contained many elixirs, cough suppressants, and medicines for "women's ailments" that all contained narcotics (Brecher et al., 1972; Berridge & Edwards, 1981). In Britain, opium was just another commodity and many individuals experimented with cultivation (Berridge & Edwards, 1981). Opium was freely used and not restricted to medical use. Berridge and Edwards (1981) state that nonmedical use of opium was very common in the nineteenth century. Opium was also used by the medical profession in the treatment of insanity. However, this practice had changed dramatically by the end of the century, as opium use was then believed to be a cause of insanity (Berridge & Edwards, 1981).

In Britain, by the late nineteenth century, medical and public health organizations rallied against the use of patent medicines, which were excluded from the 1868 Pharmacy Act. By 1908, the Pharmacy and Poisons Act had changed the status of opium in response to ideological shifts caused by class
tensions, industrialization and the emergence of a more clearly defined medical profession (Berridge & Edwards, 1981). The issues of recreational opium use and infant doping by the lower classes were identified as social problems by the emerging medical profession and self-medication was discouraged. The control of opium was perceived as a professional matter and control was seen as necessary. Subsequently, the government granted regulation to the medical profession.

Murray (1988) suggests that a similar process of regulation and control of patent medicine took place in Canada during the late 1800s and early 1900s. During the early 1800s there was a lack of doctors in rural areas of Canada. Many families therefore relied on patent medicines to treat illness (Murray, 1988). The patent medicine trade often sensationalized the healing qualities of its medicines, and many of its claims were fraudulent (Murray, 1988). Many patent medicines contained drugs such as cocaine, opium, and morphine, though consumers were often unaware of the contents of the medicines they bought (Murray, 1988).

Murray suggests that prior to the Opium and Drug Act of 1911, there was also concern by the new and powerless medical and pharmaceutical professionals about the "popular and rapidly growing trade in patent medicines - substances that offered an inexpensive...door-to-door, through the mail, and at the corner store availability to people as well as lost
revenues to the physician and pharmacist" (Murray, 1988, p. 83). Patent medicines were viewed as "quack medicines" by the medical profession, and the harm caused by self-medication and infant doping was discussed in medical journals in the early 1900s (Murray, 1988). However, there was no public concern about patent medicines at this time (Murray, 1988). Medical and pharmaceutical professionals created a moral issue in order to gain professional and economic status in Canada. Both professions lobbied for control of patent medicines and were eventually successful (Berridge & Edwards, 1981; Murray, 1988; Musto, 1987). Similar shifts occurred in the U.S. and in Europe.

As noted above, narcotics have been available for centuries. However, it was not until the twentieth century that criminal prohibitions were enacted against the use and sale of narcotics. Prior to the twentieth century, opium was "an important item of commerce, and in some periods it was the most widely used medicinal drug" (Weil & Rosen, 1993, p. 82). In addition, by the late 1800s the use of coca in tonics and wines became popular in Europe and North America (Weil & Rosen, 1993). It was not until the 1900s that coca and cocaine use was criminalized.

Before the passage of Canada’s first narcotic legislation, narcotic users were not singled out or treated differently from the rest of society. One would not have identified the lifestyle of a narcotic user as criminal.
Because the drug was legal to obtain and use, narcotic users could maintain a "normal life." Their private usage was not a public concern, and narcotics were used widely by working-class and poor people (Berridge & Edwards, 1981).

In the nineteenth century, it was quite common for physicians to prescribe the use of narcotics for menstrual and menopausal discomforts (Brecher et al., 1972; Weil & Rosen, 1993). Upper-class women, as opposed to poor women who could not afford to see doctors, were prescribed narcotics. Opium-eating was often perceived as an "aristocratic vice that prevailed more extensively among the wealthy and educated classes" (Brecher et al., 1972, p. 18). These people were affluent and productive and held roles of authority. They were not perceived as "addicts" and they participated in life fully and had professions and families.

Prior to 1908, if a person's narcotic use was discussed at all it would have been seen as a personal matter, not subject to moral or legal sanctions. The words "addict" and "addiction" were not used in the nineteenth century (Alexander, 1990; Brecher et al., 1972). Narcotic users were not cut off from the rest of society, nor were they stigmatized for their use of narcotics. The prevailing view of the narcotic user before the twentieth century was of a middle- to upper-class woman or man who was a law-abiding citizen.
II. THE EMERGENCE OF CRITICAL DRUG RESEARCH

Traditional writers on the subject of drugs have claimed that the criminalization of drugs emerged subsequent to the recognition of the inherent dangerousness of specific drugs. Since the criminalization of drugs in Canadian society, there has been a shift in ideology concerning narcotic legislation and illicit drug use. Many studies illuminate the shifts in the illicit drug-using population and in medical, sociological, criminological and psychological literature and research (Alexander, 1990; Blackwell, 1983; Blackwell & Erickson, 1988; Boyd, 1983, 1984, 1991; Boyd, Elliott, & Gaucher, 1991; Erickson et al., 1987; Green, 1979,1986; Hadaway, Beyerstein, and Youdale, 1991; Matthews, et al., 1995; Small, 1978; Solomon, 1988; Solomon and Green, 1988; Solomon & Madison, 1976-1977).

During the 1960s and 1970s, many studies were undertaken to understand the wide use of illicit drugs in Western countries. In the United States, returning Vietnam veterans and individuals aligned with countercultures used drugs more openly than had the preceding generation. Media attention and political campaigns brought the issue of illicit drug use to the attention of ordinary citizens in Canada, the U.S. and Europe.

As early as 1960, a critical perspective emerged related to illicit drug use in North America. This perspective challenged past assumptions concerning the inherent
dangerousness of illicit drugs and sought to examine the social, economic and political environment in relation to the criminalization of drugs. Traditional research on illicit drug use was criticized by an emerging group of North American researchers for failing to address narcotic policy and society's reaction to the addict following the Harrison Act, the first narcotic legislation in the U.S. (Becker, 1953; 1963; Lindesmith, 1965; Schur, 1962). Criminal and medical models of addiction were analyzed. Early critical writers from the 1950s to the 1970s favoured a medical model which supported the use of physicians to treat individuals addicted to drugs, rather than a criminal model which perceived the drug user as criminal (Judson, 1974; Lindesmith, 1965; Schur, 1962; Zinberg, Harding, & Apsler, 1978).

By the 1960s, the process of criminalization and the roles of moralism and class and race had begun to be examined. The rejection of consensus interpretations of the criminalization of drugs was advocated by critical writers (see Boyd, 1984; Green, 1979; Musto, 1987; Preble & Casey, 1969; Small, 1978; Solomon & Madison, 1976-77). The fictional line separating licit and illicit drugs was questioned, as was the myth portraying illicit drugs as more harmful and dangerous than licit drugs. Several early writers laid the groundwork for a critical analysis of the criminalization of drugs in North America and Europe.
As early as 1956, social science research began to examine the many negative assumptions surrounding illicit drug use. A University of British Columbia study examined the harmful effects of narcotic addiction in British Columbia. The authors concluded:

To our surprise, we have not been able to locate even one scientific study on the proved harmful effects of addiction. Earlier investigators had apparently assumed that the ill effects were so obvious as not to need scientific verification, or they, too, had accepted without question the traditional beliefs on the harmful effects of narcotics (Stevenson et al., 1956, p. 510).

Stevenson et al. (1956) concluded that the general public in Canada quickly accepted the picture of the illicit drug user as delinquent and criminal.

In the U.S., Schur (1962) began to examine the correlation between policy and the behaviour of illicit drug users, claiming that users' behaviour is partially shaped by prevailing legal and social definitions of addiction. Schur noted that U.S. history has been shaped by the scapegoating and policing of morals, regardless of the record of the failure of such tactics. He also noted how U.S. drug legislation, attitudes and policies contributed to a "police state" for narcotic users. In contrast to the legal model that prevailed in the U.S., Schur supported the British system, where a medical model of addiction prevailed.

Like Schur (1962), Lindesmith (1965) supported the establishment of a medical model of addiction to replace punitive criminal sanctions in the U.S. Lindesmith saw the
medical model employing private physicians to treat illicit drug users. He also brought to light the unethical strategies employed by the police to entrap illicit drug users and the threat of punishment as leverage against uncooperative users. He cited cases of harassment by the U.S. Narcotic Bureau, noting that he had been harassed for voicing and maintaining views in opposition to those of the Bureau. Furthermore, he explored how punitive narcotic control systems established and sanctioned by the U.S. have contributed to more serious drug problems and the infringement of basic rights.

During this same period in the U.S., Becker's (1963) groundbreaking study * Outsiders examined the process of becoming deviant, using the sociological concept of the deviant career. Rather than examining the consequences of the Harrison Act, Becker (1963) applied the concept of career to drug users (among others), and noted that they pass through a recognizable pattern of stages. At each stage in a deviant "career" observers may subject potential deviants to stigmatizing processes, though other deviants, more committed to the deviant act, may redefine the activity in a positive light.

Another concept Becker constructed in relation to deviant careers was the notion of "master status." Becker claimed that once a devalued status became public knowledge, it would override all other auxiliary traits. Subsequently, the auxiliary traits (e.g., being a parent, teacher, husband or
wife) are overlooked, and the master status overrides all other status characteristics. Therefore, for individuals who have been publicly labelled "drug users," the label becomes their master status and the public reacts to them negatively regardless of their other status characteristics. Becker concluded that it is the public's reaction to the deviance, rather than inherent qualities of the individual deviant, that shape deviance and crime. Becker's focus on moral entrepreneurs and the social creation of rules supports study of those who create rules and laws, rather than just study of those labelled deviant and criminal. Later studies began to focus on the law maker, in addition to the law breaker.

Brecher et al. (1972) also discussed the dangerousness of illicit and licit drugs within a historical context. They made clear that it is licit drugs, not illicit drugs, that are most harmful to health. Furthermore, Brecher et al. demystify the illicit drug user by examining drug use and the drug user prior to criminalization. They note that:

By far the most serious deleterious effects of being a narcotics addict...today are the risks of arrest and imprisonment, infectious disease, and impoverishment -- all traceable to the narcotics laws, to vigorous enforcement of those laws, and to the resulting excessive blackmarket prices for narcotics (1972, p. 22).

Brecher et al.'s (1972) recommendations and insights were ignored by the U.S. government. In the U.S., as in Canada, drug legislation has become harsher, contributing to the rise of the illegal market and to the infringement of human rights.
Research illuminates how the real evil of illicit drug use is not the drug itself, but the way society seeks to regulate and control illicit drug users (Waldorf & Reinarman, 1975).

Early U.S. studies also broadened the discussion of illicit drug use to encompass "states of consciousness" and to explore why people choose to use drugs and to alter their consciousness. Western culture has negative attitudes toward altered states of consciousness. With the exception of alcohol intoxication, all states of consciousness outside of regular, normal states are associated with psychopathology (Tart, 1972). Weil (1972) asserts that the experience of states of consciousness other than ordinary waking consciousness is positive and can be reached through many means, drugs being only one. He then introduces the concepts of "straight thinking" and "stoned thinking." Weil is not describing different groups of people. Rather, he is describing two ways of using the mind. Characteristics of straight thinking include intellectual verbal descriptions of reality. Weil notes that the "intellect is merely the thought producer of the mind and that thoughts are not realities" (Weil, 1972, p. 120). Consequently, Weil concludes that a mind functioning in the straight way feels threatened by different states of consciousness and the possibility of other forms of reality. Rejecting both the criminal and the medical models of addiction, Weil (1972) claims that all societies (excluding
that of the Inuit) use drugs and that the desire to change consciousness is innate.

In addition, Weil refutes research that perceives drug use as always harmful. He concludes that altered states of consciousness can be positive and that narcotic users would be healthy if it were not for harsh drug legislation. Several years later, Trebach (1982) drew on earlier critical research to form a rather unique argument for decriminalizing heroin in the U.S. and elsewhere. He argues that people enjoy the rituals of doing drugs, both licit and illicit, as well as changing consciousness. Many critical drug writers have now begun to explore aspects of positive drug use and how current drug policy denies the existence of such a phenomenon (Alexander, 1991; Hadaway, Beyerstein, & Youdale, 1991; Henderson, 1993a, 1993b; Wodak, 1992).

III. A CRITIQUE OF THE CRIMINALIZATION MODEL

The preceding section discussed the emergence of critical drug research. This section will examine Canada's Narcotic Control Act and Food and Drug Act, and current drug offences. Canada's first Opium and Narcotic Act was enacted in 1908 in response to Mackenzie King's recommendations following the anti-Asiatic riots in Vancouver, B.C., in 1907. The riots were set off by white workers who were motivated by economic and racial fears. King, then the Deputy-Minister of Labour, came to Vancouver to settle damage claims from the riots after being approached by two opium merchants seeking restitution.
King was surprised by the unregulated Chinese opium industry in Vancouver. However, it was not until several affluent Chinese Canadians complained about the opium industry that King saw a way of getting "some good out of this riot" (Boyd, 1984, p. 115). King recommended that the importation, sale and manufacturing of opium be regulated.

King had no evidence of physiological harm caused by opiates. Nevertheless, he was able to convince the federal government that white women and men were being corrupted by Chinese opium merchants and that fairly large profits were being made by Chinese merchants (Boyd, 1984). Economic fears, racism and moralism influenced the creation of narcotic legislation. Prior to the 1908 and 1911 Narcotic Acts, the categories of medical or nonmedical use of drugs did not exist in law. The 1911 Opium and Drug Act restricted the possession and sale of cocaine, morphine, opium and eucaine, placing the burden of proof on the offender.

The Narcotic Control Act and the Food and Drugs Act

Currently, there are two federal statutes controlling illicit and licit drug use in Canada: the Narcotic Control Act (NCA) and the Food and Drugs Act (FDA). Within these two statutes there are three legal categories: narcotics, controlled drugs and restricted drugs. There are now over 100 different drugs controlled under the NCA. Illicit drugs listed in the NCA schedule include marijuana, heroin and cocaine, and the NCA does not distinguish between offences related to each
of these drugs. In Canada, a marijuana conviction is subject to the same penalties as a cocaine conviction.

The Food and Drug Act (FDA) regulates the safety and advertisement of food, cosmetics, medicines and medical devices. In the 1960s, two sections were added to the FDA to control the use of specific drugs such as amphetamines, LSD and MDA. There are two categories of drugs in the FDA: controlled drugs and restricted drugs. Restricted drugs, such as LSD and MDA, carry a three-year maximum penalty for possession. The possession of controlled drugs, such as amphetamines, is not a criminal offence. Boyd (1990) notes that the categorization of drugs as narcotics, restricted drugs, and controlled drugs is a "social fiction" with no relationship to dangerousness (p. 38). Nor are there "bad or good" drugs. Rather, individuals have either "good or bad relationships with drugs" (Boyd, 1991, p. 12).

In Canada, the federal government has legislative authority over criminal law, including drug legislation. In 1919, the Royal Canadian Mounted Police (RCMP) became the federal enforcement agency for the NCA. Since the enactment of the NCA, the RCMP, as well as provincial and municipal police, have established drug enforcement divisions. Because narcotic use, like any illegal drug use, is considered a "victimless" crime, it is difficult for law enforcers to identify illicit drug users and distributors. Illicit narcotic users rarely complain to the police, nor are they easily distinguishable
from other people in the general population. The police have therefore developed many proactive and controversial procedures to obtain narcotic arrests and convictions (Alexander, 1990; Cohen, 1985; Solomon, 1988; Stoddart, 1982; Wisotsky, 1986).

Most of Canada's special legislative powers were enacted in the 1920s. Currently these include, but are not confined to, powers of forfeiture, search and seizure and electronic surveillance. Originally the public did not oppose this broadening of power, as they saw the target population as "relatively small and predominantly Chinese" (Solomon, 1988, p. 263). There was an understanding that these new laws would not be used against ordinary citizens.

The use of informants, disguised police officers and undercover agents has frequently been employed since the criminalization of narcotics. Stoddart (1982) explores the lifestyle of undercover agents, their disregard of the law, and their abuse of the people with whom they are interacting. Both Stoddart (1982) and Wisotsky (1986) warn that it is dangerous to allow police to act like criminals in order to arrest narcotic users. Historically, Canadian police and courts have been more concerned with "crime control" than with "due process" (Griffiths & Verdun-Jones, 1989). However, the Canadian Charter of Rights and Freedoms is concerned with individual rights, and there have been some successful challenges to some of the more "draconian aspects" of the
Narcotic Control Act under the Charter (Solomon & Usprich, 1991). Perhaps we will see a balance between individual rights and police powers in the future. Currently, however, few civil suits are brought against the police, for most people charged with drug offences are young, poor and legally naive (Solomon & Usprich, 1991).

The criminalization of drugs undermines civil liberties and promotes punishment, even though there is no basis for using criminal law to restrict specific drug use. The arguments for continued criminalization of specific drugs are both political and ideological.

Canadian Drug Offences

In Canada, there was a total of 60,594 drug charges in 1994, and cannabis accounted for two-thirds of all drug offences (Statistics Canada, 1995). Historically, most drug charges are for possession. In 1994, 75 percent of possession charges were for cannabis (Statistics Canada, 1995). Under the four major categories of drug offences - possession, trafficking, multiple doctoring, and importation - possession accounts for 62 percent of the total number of drug charges in 1994 (Statistics Canada, 1995, p. 25). Only 2 percent of the total number of drug charges relate to importation. Twenty-eight percent are for trafficking and 8 percent are for cannabis cultivation and controlled-drug crimes (Statistics Canada, 1995, p. 25).
There have been substantial shifts in the pattern of convictions for cannabis offences. In 1967, of the 1,000 Canadians charged with possession of marijuana, almost half were sent to jail. In 1975, over 32,000 Canadians were convicted of possession of marijuana. Jail was therefore no longer considered a practical solution and sentencing included more fines and probation orders (Boyd, 1990, p. 45). Nevertheless, marijuana convictions still comprise the majority of drug charges in Canada (Single et al., 1994; Statistics Canada, 1995).

Even though the NCA does not separate marijuana from other drugs such as cocaine and heroin, Canadians receive different sentences depending on the type of drug used. Marijuana convictions usually receive the lowest penalties, and heroin convictions receive the harshest penalties (Health and Welfare, 1991, p. ix). There were 732 admissions to federal adult correctional institutions for drug offences in 1991-1992 - an increase of 13.7 percent from the previous year (Single et al., 1994, p. 261).

In contrast to the 56,123 drug offences in Canada in 1991, there were 221,185 alcohol-related offences (excluding traffic offences) in the same year, and 140,068 drinking and driving offences (Single et al., 1994, p. 256,258). The most serious drinking and driving charge - causing serious bodily harm or death - accounted for 1,445 offences, or 1 percent of the total number of offences (Single et al., 1994, p. 258).
Alcohol consumption by both victims and assailants plays a significant role in violent crime. Both licit and illicit drugs are associated with 70 percent of the homicides in one Canadian study. However, alcohol and pharmaceutical drugs are associated with the majority of all homicides (Boyd, Elliott, & Gaucher, 1991, p. 79, 80). Drunken driving accidents causing death are twice as common as all homicides combined in Canada (Boyd, Elliott, & Gaucher, 1991).

There is no link between cocaine, heroin or marijuana (in the pharmacological sense) and violent crime (Hadaway, Beyerstein & Youdale, 1991). Drug-related crime is more a result of our prohibition laws than of illicit drugs (Hadaway et al., 1991). The inflated price of narcotics and the existence of the blackmarket inevitably affect both user and distributor. Disputes over drug markets and distribution have led to some "gang slayings" in Canada, which may have been due to the expansion of the illicit drug market (Boyd, Elliott, & Gaucher, 1991). The majority of illicit drug users are not involved with crime outside of the purchasing of their drugs, and those who are involved with crime usually participate in nonviolent crime such as prostitution, theft, cheque forgery and drug dealing (Alexander, 1991). Illicit drugs are a factor in less than 3 percent of homicides in Canada (Boyd, Elliott, & Gaucher, 1991, p. 73). Alcohol is a factor in about 30 percent of all homicides in Canada (Boyd et al., 1991, p. 73). Alcohol, a legal drug, appears to be associated with violent
behaviour, whereas such illicit drugs as heroin and marijuana are not (Boyd, Elliott, & Gaucher, 1991; Hadaway et al., 1991).

In Canada, women tend to use less alcohol and illicit drugs than men. However, women are more likely than men to use licit drugs, including though not restricted to, aspirin and pain relievers, tranquillisers and sleeping pills (Single et al., 1994). In Canada, there has been a decline in the use of both illicit and licit drugs by both men and women between 1985 and 1990. The most notable decline has been in the use of illicit drugs by women (Single et al., 1994, p. 106). Marijuana is still the most popular illicit drug in Canada, used by about 5 percent of the population, in contrast to the 1 percent of the population using cocaine (Single et al., 1994, p. 106).

IV. PHARMACEUTICALS: THE LEGITIMIZATION OF "MEDICINE"

Set against the backdrop of the criminalization of drugs in Canada has been the emerging, and now firmly entrenched, pharmaceutical industry. Due to pressure from the newly formed medical profession, the Patent Medicine Act was passed in 1908. The act required that all patent medicines list their ingredients and restricted the use of specific ingredients, such as cocaine. This initial legislation paved the way for the development of the pharmaceutical industry through the government and the medical profession (Lexchin, 1984, p. 15). Pharmaceutical companies were responsible for the "creation"
and advertisement of new drugs; the government was to regulate this trade; and the medical profession was to prescribe each pharmaceutical. Consequently, intense lobbying and advertisement by pharmaceutical companies has been directed at doctors in order to expand the use of drugs. Furthermore, according to Lexchin (1984), new diseases have been created by the pharmaceutical companies, which require more drugs to alleviate symptoms.

The pharmaceutical industry has created fictional boundaries in regard to what constitutes a medical drug, legitimizing drugs dispensed by the industry and prescribed by doctors. Doctors cannot prescribe cocaine or LSD in Canada; they can only prescribe what are defined as legitimate pharmaceuticals. Illicit drugs are separated from pharmaceutical drugs in that their use is illegal. However, the status of specific drugs can change over time, and "illegal drugs can be transformed into legal drugs if they are prescribed for relief from pain or the treatment of illness. And legal drugs can be transformed into illegal drugs if they are used without a physician's approval" (Boyd, 1991, p. 108).

Boyd (1991) notes that it is the line separating "pleasure and pain" that distinguishes forms of illicit and licit drugs. "The taking of medicine is socially acceptable; the taking of drugs is not" (Boyd, 1990, p. 44).

The so-called "dangers" of illicit drugs are widely depicted by both government and the media. But the real
dangers of legal drugs, including alcohol, tobacco and pharmaceuticals, are rarely publicized. The inappropriate use of several pharmaceuticals, including Thalidomide, diethylstilbestrol (DES) and Valium, illustrate the profit motive of the industry and the failure of pharmaceutical companies and government to protect the consumer.

During the late 1950s and early 1960s, the pharmaceutical industry was transformed through the creation of mood-modifiers, or tranquillizers, as they are commonly called. The creation of such drugs as Librium and Valium (the world’s most prescribed drug) ushered in a new era of prescribing tranquillizers to deal with the stress of everyday life (Harding, 1986).

Lexchin (1984) challenges conventional, or one-dimensional, views of drug use. His exploration of Canada’s pharmaceutical drug industry reveals the issue of who the real drug "pushers" in society are. The aggressive advertising employed by pharmaceutical companies targeting women, the elderly and, recently, third-world countries (Ettorre, 1992; Lexchin, 1984; McDonnell, 1986) exposes the profit motive inherent in marketing, as opposed to the promotion of health. It is alcohol, tobacco and pharmaceutical drugs that are most harmful to health, rather than illicit drugs. However, this reality is submerged in drug-war rhetoric.

V. THE SOCIAL CONSTRUCTION OF DRUG USE AND DRUG ABUSE

The Disease Model
Although there is a large body of literature that demonstrates people's wide range of reactions to drugs, the disease/criminal model of addiction is paramount in North America. As mentioned earlier, illicit drug use is predominantly constructed as a medical and/or legal problem. At first glance it appears that these two models are incompatible. However, North American drug laws and treatment protocols have incorporated a disease/criminal model of addiction which embraces the dual premise that addiction is a disease and that the illicit drug user is a criminal (Alexander, 1990; Klein, 1983).

Drug treatment services, self-help groups and individuals have also adopted the premise that addiction is a biological, progressive disease that is predictable and irreversible and culminates in loss of control if the individual continues to use drugs. Therefore, drug treatment by trained professionals and support through Alcoholics Anonymous (A.A.) and Narcotics Anonymous (N.A.) groups are recommended for helping individuals who hope to achieve and maintain abstinence. The "12 step" philosophy of A.A. states clearly, in Step One, that individuals are "powerless" over their drugs. Denial of addiction is a cornerstone of the disease model, and efforts to regard one's drug use in any other terms are perceived as evidence of denial. Finally, the disease model of addiction maintains that, like other progressive diseases, addiction is
permanent and relapse may occur at any time. Abstinence is therefore required.

Levine (1978) notes that the concept of alcoholism as a progressive disease is a fairly new concept originating in the late eighteenth century and later becoming a premise of the American Temperance Movement. Prior to the invention of the disease model of addiction, alcohol use was considered a private affair. People were understood to use alcohol because they wanted to, not because they needed to (Levine, 1978). Alexander (1990) states that the traditional usage of the term "addiction" did not connect addiction with drugs until the nineteenth century. The early American Temperance Movement, consisting mainly of white, middle-class people, saw alcohol as the source of many prevailing social problems. Self-restraint and abstinence were seen as the key to helping individuals maintain control over their actions (Levine, 1978).

The disease model of addiction is predicated on a set of precepts adopted by a small group of long-term alcoholics in the 1930s. These were the original members of A.A. (Peele & Brodsky, 1991). Peele and Brodsky (1991) show how modern medicine has adopted the premise of A.A. for all drug use and some other forms of behaviour, even though scientific evidence "contradicts" the disease model of addiction. For example, there has been no substantial evidence to support a biological or genetic mechanism that accounts for addictive behaviour.
(Peele and Brodsky, 1991, p. 26). Progression is not inevitable, nor do all drug users lose control. In fact, the majority of drug users are able to control their drug use, and cease use without any medical or drug treatment services (Alexander, 1990; Biernacki, 1986; Blackwell, 1983; Peele and Brodsky, 1991; Trebach, 1982; Waldorf et al., 1991; Winick, 1962).

Vaillant (1994), a leading proponent of the disease model of addiction, agrees that there is no known biological defect resulting in alcoholism. However, he states that the disease label allows alcoholics to receive the medical treatment they require, and the label gives them unprejudiced access to “emergency rooms, detoxification clinics, and medical insurance” (p. 204). Labelling alcoholism as a disease may provide unlimited access to medical treatment. However, it fails to recognize the success of drug users in achieving their own control mechanisms. It also fails to recognize the danger in labelling alcoholism a disease when there is no credible scientific evidence to support a biological defect (Fingarette, 1994). Finally, it fails to recognize the wide range of people’s responses to drug use. Stevenson et al. (1956) noted that narcotic users were able to cease use without any medical treatment. Many users were able to control and cease use for long periods of time or permanently. Other research describes how narcotic users were able to cease using narcotics of their own volition (Biernacki, 1986; Blackwell,
1983; Trebach, 1982; Winick, 1962). Several studies demonstrate that the majority of cocaine users are able to control or cease use without the aid of medical or drug treatment services (Erickson et al., 1987; Matthews, 1995; Reinerman, 1979; Waldorf et al., 1977; Waldorf et al., 1991).

MacAndrew and Edgerton (1969) illuminate how drunken comportment is determined by cultural norms rather than by biological or pharmacological factors. In reality, all drug use, licit and illicit, is shaped by historical, political, economic, cultural and social variables. MacAndrew and Edgerton (1969) examine cross-cultural evidence in relation to drunken comportment. They state that drunken comportment is essentially a "learned affair," and people learn about drunkenness through socialization. In some cultures people are not held responsible for their actions when drunk; in contrast, other cultures take pride in maintaining that alcohol does not produce anger and aggression. The behaviour of people from these cultures while under the influence of alcohol supports their claims (MacAndrew and Edgerton, 1969).

The disease/criminal model of addiction fuels the war on drugs by portraying drug users as out of control and dangerous. Both conservatives and liberals describe addiction as completely destroying "free will" and addicts as having only one goal -- their next fix (Cain, 1994, p. 3). Draconian drug laws and drug treatment services reflect the underlying premise of the criminal/disease model of addiction. Rather
then attempting to create practical solutions and services for illicit drug users, the disease/criminal model of addiction endorses the policing and control of illicit drug users (Klein, 1983).

A Critique of Drug Treatment Services

The faulty construction of drug use and addiction embodied in the disease model shapes drug treatment services, which have become a growing industry in North America regardless of their very low success rates (Alexander, 1990; Brecher, 1972; Peele, 1989; Peele & Brodsky 1991; Rogers & Mitchell, 1991). Peele (1989) states that treatment centres produce a success rates of less than 10 percent (p. 78). Brecher et al. (1972) found that the success rates of compulsory treatment programs for narcotic addicts ranged from 0 to 9 percent (Chapter 10). They summarize by stating: "No effective cure for heroin addiction has been found--neither rapid withdrawal nor gradual withdrawal, neither the drug sanatoriums of the 1900s, nor the long terms of imprisonment" (1972, p. 83). Fingarette (1994) notes that government and individual research demonstrates that disease-oriented treatment programs have been a failure. Rather than continuing to advance the disease-oriented treatment model, Fingarette (1994) suggests that psychological and sociocultural research is necessary, for "heavy drinking is not primarily a biochemical or medical problem but a human and social one" (p. 210).
Peele (1989) suggests that "people respond best to treatment that builds on their existing perceptions and experiences" (p. 80). Research documenting both occasional and addicted users who control their drug use and stop of their own volition (Alexander, 1991; Biernacki, 1986; Blackwell, 1983; Erickson et al., 1987; Matthews, 1995; Peele and Brodsky, 1991; Reinarman, 1978; Stevenson et al., 1955; Waldorf et al., 1991; Winick, 1962) suggests that disease-oriented drug treatment, and especially compulsory treatment, may not be effective for most people who use drugs, and can be harmful.

Drug treatment is often mandatory, stipulated in sentencing and probation orders. Therefore, the disease model of addiction has been adopted by the criminal justice system even though incarcerating users for possession of illicit drugs would appear to be cruel and inhumane treatment if addiction is a biological, progressive disease. Unfortunately, such contradictions do not appear to concern criminal justice and drug treatment professionals. For example, in British Columbia, in May 1978, Bill 18, the Heroin "Treatment Act, became law. Bill 18 was enacted to treat the narcotic user "as a sick person needing help, rather than as a criminal" (Boyd, Millard & Webster, 1988, p. 393). Section 3 of the Act:

created professional evaluation panels that would determine whether a given individual would be best committed for treatment for up to six consecutive months. Individuals suspected by police of having "a dependency on a narcotic" would be compelled to attend at an "area co-ordinating centre" for the
purpose of ascertaining the best course of
treatment for their dependency (Boyd, Millard &
Webster, 1988, p. 394).

Bill 18 was challenged in October 1979, and the British
Columbia Supreme Court declared the Heroin Treatment Act
unconstitutional.

Although medical and psychological assessment and care of
drug users may appear to be less punitive than criminal
sanctions, treatment and indeterminate sentencing may violate
Sections 9 and 12 of the Charter. These sections state that
"everyone has the right not to be arbitrarily detained or
imprisoned" and that "everyone has the right not to be
subjected to any cruel and unusual treatment or punishment"
(Canada Act, 1982. s. 9, s. 12).

Alternatives to the Disease Model of Drug Treatment

Until recently, the medical and legal communities in
North America have been unwilling to recognize other models of
drug use outside of either the disease model of addiction or
the disease/criminal model. Overwhelmingly, drug treatment
services in North America are based on the disease model and
incorporate aspects, if not all, of the 12 steps of Alcoholics
Anonymous. Critical interpretations (Alexander, 1987;1990;
Peele & Brodsky, 1991; Waldorf, ReinArman & Murphy, 1991),
theories of harm reduction (see O'Hare, Newcombe, Matthews,
Buning, & Drucker, 1992) and feminist analyses of drug
treatment for women (Ashbrook & Solley, 1979; Bepko, 1991;
Ettorre, 1992; Kasl, 1992; Reed, 1987) have expanded to include alternative views of drug use.

Legal and medical literature often refers to all drug use, and especially illicit drug use, as "drug abuse." Imprecise terms and definitions have hampered drug research and policy. Zinberg, Harding, and Apsler (1978) state that puritanical values and ignorance of variable drug-using styles have led to much of the current confusion. The term "drug abuse" was originally applied to the use of cocaine, and then to describe the use of opium by Chinese-Americans (Zinberg et al., 1978). Like the word "addiction," which is linked to culturally disapproved use of certain drugs, the term "drug abuse" came into use only recently. Zinberg et al. (1978) note that these are generally accepted as scientific terms but that on closer examination this terminology "reveals a long history of pseudo-scientific understanding and application" (p. 14). "Drug abuse" and "addiction" are moral rather than medical terms (Zinberg et al., 1978). When drugs are used without medical authorization, the user is considered a drug abuser, addicted and criminal.

Rather than adopting the disease/criminal model of addiction, both Alexander (1990) and Peele and Brodsky (1991), have developed alternative explanations of drug use. Peele and Brodsky (1991) have developed the Life Process Program, which emphasizes social environment, natural processes, individual strength, individualized treatment, coping mechanisms and
personal efficacy (p. 168). Alexander (1990) notes that there are many patterns of involvement with drugs, and drug use is not equal to drug abuse and addiction.

Expanding and modifying Jaffe's (1985) terms to describe patterns of drug use, Alexander (1990) introduces the term "continuum of involvement" to describe patterns of drug use. These include abstinence, experimental use, circumstantial use, casual use, regular recreational use, dependence and addiction. Drug use is not static and individuals can move within the continuum. Dependence, as defined by Alexander, may not be cause for concern, and many illicit drug users, coffee drinkers and cigarette smokers can be described as dependent users. Overwhelming involvement distinguishes addictive use from dependent use. However, Alexander does not perceive all addictive patterns of use as negative. Some people describe their addiction, or overwhelming involvement, in positive terms.

The concept of "positive addiction" was explored by Glasser (1986) when he noted that many activities, such as reading and running, may be defined as addictions, and these addictions may not be negative. Rather, they are positive experiences. Drawing on the concepts of positive and negative addiction, Alexander (1990) illustrates how addiction is "(1) not restricted to alcohol and illicit drugs, or to drugs at all, (2) not inevitably harmful, and (3) not necessarily
linked to withdrawal symptoms or tolerance" (Alexander, 1990, pp. 115, 116).

Rejecting the disease/criminal model, Alexander (1990) outlines the "adaptive" model. This model describes addiction as a way of:

adapting to a dire situation.... combinations of social and constitutional problems sometimes result in a failure of psychosocial integration, that is, in people not finding a way to live in society that is satisfactory both to society and to themselves (Alexander, 1990, p. 258).

Failure to achieve psychosocial integration leads people to search for alternative lifestyles. Drug use may be a choice which appears to be maladaptive to the outsider, but is adaptive for the individual in a dire situation (Alexander, 1990).

**Harm Reduction: A New Approach**

The emergence of the harm reduction model in Europe during the 1980s has widened the debate surrounding illicit drug use and drug treatment services. Harm reduction advocates recognize that the line separating licit and illicit drugs is culturally constructed, and has nothing to do with inherent dangerousness (O'Hare, 1992). Harm reduction recognizes that historically people have always sought ways to change consciousness through the use of drugs. Accepting this reality, harm reduction seeks to minimize the harm that can be caused by drug use to the individual and to society (O'Hare, 1994). Rather than trying to coerce individuals to abstain from drug use, harm reduction advocates accepting drug use and
focusing on making drug use safer (O’Hare, 1994). In addition, harm reduction attempts to search for pragmatic interventions, rather than interventions based on morality (O’Hare, 1992).

Harm reduction advocates note that drug use ranges from positive experiences to problematic ones; therefore, abstinence is unnecessary and unrealistic for many drug users. Harm reduction does not reject abstinence. Rather, it includes abstinence in a wide range of options for the drug user. User-friendly programs such as needle exchanges and methadone maintenance would fall under the philosophy of harm reduction. Harm reduction is not legalisation, and harm reduction measures can be carried out without the legalization of drugs (O’Hare, 1994). The harm reduction movement offers a serious counterbalance to the supremacy of the disease model of addiction, and harm reduction is growing in popularity in North America.

Methadone maintenance is one component of the harm reduction philosophy. Methadone maintenance programs emerged in the 1960s in the United States. Dole and Nyswander were the first doctors to experiment with methadone maintenance, and they later established the first methadone clinics in the U.S. (Dole, 1987). Originally, methadone was prescribed to individuals addicted to heroin, and it was believed that methadone would block the craving for heroin (Brecher et. al., 1972). Methadone was offered to individuals addicted to heroin who wanted to detox, and as maintenance for those individuals
who were not ready to detox. Illegal prices and adulterated illicit drugs make it difficult for drug users, and especially poor users, to maintain a healthy, stable lifestyle. Methadone maintenance appears to be successful in lowering drug-related crime and improving physical health, and allows users to stabilize and to participate in law-abiding activities and employment (Brecher et. al., 1972).

At first glance, the emergence of methadone maintenance for individuals addicted to heroin appears to be positive. However, the limitation of drug maintenance to methadone exclusively, the rigidity in prescribing methadone and the human rights infringements inherent in methadone programs in North America warrant attention. Alexander, Beyerstein, and MacInnes (1987) discuss methadone treatment protocols in British Columbia, and review the international literature on methadone treatment. Rigidity, compulsory urine testing, compulsory counselling, low-dose methadone regimens and the prescription of methadone by clinics rather than private physicians were revealed as hindering maintenance and stability (Alexander et al., 1987). The authors note that low-dose methadone programs produce increased rates of arrest, crime and continued illicit drug use. Supervised urine testing, besides being expensive, is repellent to methadone patients. Humphries et al. (1992) have pointed out how unreliable urine testing is. Such testing may result in false positive results. Alexander, Beyerstein, and MacInnes (1987)
describe how inflexible methadone clinics have been in the past, which has led to conflicts between staff and patients. They conclude that doctors should be able to provide personalized consultation and therapy to their methadone patients, and methadone patients should be able to choose their doctors and counselling options.

The B.C. Ministry of Health has arbitrarily changed the course of methadone maintenance in B.C. several times. Diversion of legal methadone and "cure" rather than maintenance seem to be at issue. However, the Ministry has failed to produce data to support its repressive methadone prescribing policies (Alexander, Beyerstein, & MacInnes, 1987). Rigidity and arbitrary policy changes in methadone programs directly harm patients. In B.C., methadone patients are not consulted prior to policy changes. Policy shifts have led to inhumane treatment and ineffective prescribing practices. In January 1986 the B.C. Ministry of Health announced its intention to remove the licence to prescribe methadone from all private doctors and only license doctors affiliated with government drug treatment programs. Dr. Vincent Dole criticized the announcement, as well as any methadone policy that incorporates rigid punitive guidelines (Dole, 1987). Dole (1987) states that rigidity and punitive guidelines are non-therapeutic and deter users from utilizing methadone treatment.
Rosenbaum and Murphy (1987) note that female heroin users who enter methadone treatment programs tend to be in poorer health than their male counterparts. Their ethnographic study of 100 women on methadone in the San Francisco area brings forward the lack of gender analysis in the development of drug treatment programs. They examine many of the health problems women experience while on methadone. They discuss physical changes, emotional changes, increased topping up of both illicit and licit drugs when initially on methadone maintenance, pregnancy and sexual problems. Topping up methadone with other drugs such as alcohol, Valium, cocaine and heroin was noted after women entered methadone programs. The women interviewed were concerned with the short- and long-term side effects of methadone and were often disillusioned with methadone maintenance due to associated health problems. Rosenbaum and Murphy (1987) conclude that many of the health problems that women experience while on methadone stem from poor health regimens. For example, over 90 percent of the women in the study were heavy cigarette smokers, the majority had poor diets and fewer than 5 percent exercised regularly (pp. 224, 225). Clearly, education about women's health issues should be available to women on methadone.

As discussed earlier, a harm reduction model incorporates methadone maintenance as one option in drug treatment. Such a model easily incorporates heroin maintenance programs as well. In the U.K, the British Misuse of Drugs Act allows doctors to
prescribe heroin and cocaine to individuals addicted to these substances. But Dr. John Marks (1995), one of the original harm reduction advocates, states that doctors rarely prescribe these drugs in practice. Marks (1995) notes that many doctors in London argue that drug users cannot be maintained on heroin, cocaine and other drugs, regardless of evidence supporting maintenance programs. Marks has been a vocal supporter of heroin maintenance in England for those drug users who are unable to stop. Marks's drug clinic in Widnes was closed in the Spring of 1995, due to a recent backlash against harm reduction practices. Central to the debate on drug maintenance is whether doctors should be curing or maintaining addiction (Ashton, 1995). Currently, the majority of doctors in London who advise the government support drug policy that seeks to cure addiction (Ashton, 1995; Marks, 1995). Ideological shifts by government and doctors regarding drug prescribing practices have severe consequences for individuals addicted to drugs. Years of stability may be jeopardized when doctors lower maintenance doses or cut patients off legal heroin and switch them to methadone maintenance (Ashton, 1995).

Illegal heroin is available to drug users every day. Wodak (1992) notes that take-home illegal heroin that is adulterated, unsupervised and expensive to both the user and society is available in Australia. The sale of illegal heroin in Australia is similar to that in most Western countries.
Wodak (1992) asks what system should be maintained, an illegal system with no supervision or a clinical system where the cost to the user and society will be lessened.

At the 6th International Conference on the Reduction of Drug-Related Harm, held in Florence in 1995, data on two heroin pilot programs were presented. A program is currently in progress in Switzerland, and an Australian model is in the early stages of consideration (Nadelmann, 1995). In addition the Netherlands will begin a similar experiment soon (Nadelmann, 1995). Trebach (1982) notes that drug policy must address the wide range of human approaches to drug use, for not all drug use is addictive use. In fact, nine out of ten heroin users are not addicted (Trebach, 1982, p. 289). Trebach (1982) never isolates the use of heroin and the harsh policy surrounding it from other considerations, including human understanding and compassion.

Unfortunately, the Swiss program is only available to low threshold drug users, and injecting users must come into the clinic several times a day to pick up and take their drugs on site, although other participants can take home heroin-injected cigarettes (Karel, 1993; Nadelmann, 1995). Outside of England, no heroin maintenance services are being offered to "stable" narcotic users, where they could pick up their heroin

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5Low threshold drug users are defined as drug users who suffer from economic and social deprivation and who have been unable to stabilize their drug use through conventional maintenance programs.
once a week, rather than several times a day, thus maintaining a normal lifestyle. Furthermore, outside of England, heroin maintenance programs have not addressed the full spectrum of administration of drugs. Not all drug users wish to inject drugs. This is particularly true of long-term oral methadone users who have stabilized and have not injected drugs for many years. Offering a full spectrum of administration (i.e., smoking, oral, injecting) and weekly pick-up would more fully adhere to a harm reduction philosophy. So would offering more organic drugs such as opium and liquid cocaine.

Methadone maintenance is favoured by government because methadone is thought to be easier to dispense than heroin and is cheaper. Also, methadone is not weighted with the negative mythology attached to heroin in Western countries. However, a consistent problem with methadone maintenance is the topping up of legal methadone with illegal heroin. Drug users who use heroin can stabilize on methadone, but the majority prefer heroin and continue to use illegal heroin when it is not offered by prescription (Ashton, 1995). If the goal of methadone maintenance treatment is to cease illicit drug use, then such treatment is unsuccessful, since users continue to buy and take illegal, adulterated drugs. If the goal of drug maintenance is to reduce harm by offering users an affordable, safe, unadulterated drug when they choose, or cannot stop, drug use, then both heroin and cocaine must be included in maintenance programs. The daily and sporadic drug
testing of individuals on methadone maintenance in North America is linked to the use of other illicit drugs while on methadone maintenance. Users who repeatedly have dirty screens (positive drug test results) are eliminated from methadone programs. Rather than prescribing the drug that users prefer and can stabilize on, such programs penalize heroin users who cannot limit their drug use to methadone exclusively. Individuals are deprived of human rights and subjected to humiliating and degrading practices so that professionals can monitor, control and regulate their methadone maintenance.

The availability of heroin maintenance does not assure humane or effective drug treatment and maintenance. Rather, it broadens the realm of harm reduction. If heroin maintenance is structured to meet the needs of users (as methadone treatment should be as well), human rights infringements and inhumane treatment will cease to be an issue. Punitive drug policy doesn’t work (Alexander, Beyerstein, & MacInnes, 1987; Dole, 1987; Peele & Brodsky, 1991; Trebach, 1982). The prescribing of any drug must be a cooperative venture between the medical community and drug users as long as certain drugs remain illegal.

Rather than emphasizing a single form of treatment for individuals who find their drug use problematic, harm reduction advocates and other proponents of alternatives to the disease model state that treatment must be voluntary and tailored to the individual. Drug treatment services should
never be guided by only one model of addiction and drug use. There should be a choice of heroin, methadone and cocaine maintenance as well as more organic forms such as liquid cocaine and opium, different routes of administration, low-threshold programs and programs for stable users. Rather than policy being dictated by government as it is now, drug users must have a voice in guiding program policy.

Several alternative projects have developed in which drug users and drug workers have formed temporary and permanent coalitions to dispense educational information about safe drug use. In Edinburgh, drug users and drug workers came together in response to ecstasy (MDMA) use in the dance club scene. The goal was to give out information regarding ecstasy and other drug use as quickly as possible (McDermott & McBride, 1993). McDermott and McBride (1993) note that coalitions between drug users and drug workers can challenge drug workers' image of themselves as the "expert." Drug workers can help facilitate processes whereby drug users "define and implement their own agendas" (McDermott & McBride, 1993, p. 15). McDermott (1990) points out how hypocritical it is that drug workers are still expected to remain abstinent from illicit drug use (if they wish to keep their jobs), even though many "entered the drug field because of an abiding personal interest in drug use" (p. 11).

Coalitions are a necessary step. But user groups have been successful in advocating their own concerns and
establishing their own agendas without the aid of drug workers. The Medico-social Service for Heroin Users (MSHU), also known as the Junkiebond, is the best known user group that publicly advocates legal reform and promotes and publishes educational information about drug use and human rights. Established in 1977 in Amsterdam, it is comprised of drug users, ex-users, and non-users. They advocate that drug users must decide for themselves what they wish to do regarding their own life and drug use. Central to MSHU is the acceptance of drug use and drug users. It rejects the use of centralized drug-welfare agencies. Decriminalization is one of its central goals. The MSHU is active in articulating the concerns of drug users regarding policy and consultation with city and national governmental agencies (Mol, Otter, & van der Meer, 1992).

Injection drug users (IDUs) in Australia have established IDU organizations over the last ten years to advise government about drug use and education (Wodak, 1993). The Concerned Citizens’ Drug Study and Educational Society, in British Columbia, is also comprised of drug users, ex-users, and nonusers. Its goals are education and the legalization/decriminalization of drugs. More recently it has expanded its mandate to establish small interest groups, such as the methadone group whose purpose is to advise B.C. physicians regarding methadone policy in B.C.
The unique philosophy of the MSHU and the Concerned Citizens emphasizes decriminalization/legalization of drugs, the interests and representation of drug users and the point of view that drug use does not automatically necessitate drug treatment and eventual abstinence. Both groups strive to reform the law, to educate society about drug use and to protect the human rights of drug users and others.

The harm reduction model does not advocate the decriminalization or legalization of drugs, and ultimately its pragmatic and humane proposals may be jeopardized by the harsh criminal sanctions that shape illicit drug use in North America. Historically, the social construction of specific drugs and drug users as dangerous has fuelled harsh criminal sanctions and drug treatment regimens. Many user groups noted that drug treatment may be necessary for those who wish to cease their drug use; however, they believe many drug users would be able to live stable and productive lives if drugs were legalized. The emphasis on drug treatment, rather than criminal sanctions, continues to disregard the possibility that recreational, dependent and addictive use of drugs can be positive, stabilizing and ordinary.

The user groups bring to our attention the fact that conducting research and establishing programs that embrace the philosophy of harm reduction may be difficult when a "war on drug" mentality prevails. Beyerstein and Hadaway (1990) describe how inflexible and unworkable drug policy continues
today, in spite of empirical evidence that challenges the "war on drugs" ideology. Although harm reduction does not constitute legalization of drugs (O’Hare, 1994), the criminalization of drugs and harsh penalties appear to be contrary to a harm reduction philosophy. Many harm reduction advocates personally favour some form of decriminalization or selective legalization of drugs. It has been argued that equating harm reduction with the legalization of drugs will hinder the acceptance of harm reduction, especially in the U.S., where drug use is so politicized (O’Hare, 1994). However, gaining acceptability by rejecting the more radical components of harm reduction, i.e., legalization of drugs, fails to recognize the harms that stem directly from the criminalization of drugs. Without the complementary strategy of decriminalization or legalization of drugs, the harm reduction movement will be little more than a band-aid solution. This is especially true in North America, where conservatives can appear to embrace a harm reduction philosophy by incarcerating drug users for their own safety and the safety of society. Trebach states that the legalization of drugs "is not a solution but a door that must be opened if we hope to come to grips with the problems that are tearing us apart" (Trebach & Inciardi, 1993, p. 99).

Decriminalization and Legalization

Mitchell (1991) states that Canada has a "tradition of drug research." Individual Canadian writers have contributed
to a rich body of research that is varied and critical of drug legislation and law enforcement (e.g., Alexander, 1990; Blackwell and Erickson, 1988; Boyd, 1983, 1984, 1991; Erickson, 1990; Giffen, Endicott, & Lambert, 1991; Green, 1979, 1986; Hadaway, Beyerstein, & Youdale, 1991; Small, 1978; Solomon, 1988; Solomon and Green, 1988; Solomon & Madison, 1976-1977). Several alternatives to the current prohibitionist policy have been presented, including decriminalization and legalization. Other options include a more comprehensive public health model and demand reduction policy (Erickson, 1990), uniform regulation (Mitchell, 1988) and rational drug scheduling (Green, 1988). In addition, several larger research projects have been sponsored by the government: Stevenson et al. (1956) "Drug Addiction in British Columbia: A Research Survey"; the Le Dain Commission "Final Report" (1973); and the recent report by the Office of the Chief Coroner in B.C., "Illicit Narcotic Overdose Deaths in British Columbia" (Cain, 1994). Each study criticizes current Canadian drug legislation and law enforcement practices.

Stevenson et al.'s (1956) recommendations regarding drug legislation were ignored by the federal government. Later, due to an increase in illicit drug use in Canada during the 1960s, the Le Dain commission was set up to examine the nonmedical use of drugs in Canada. In their "Final Report" (1973) the majority of commissioners recommended that the possession of marijuana no longer be a criminal offence, and that the
societal costs and benefits of drug legislation be weighed. Unfortunately, the Trudeau government and subsequent governments thereafter chose to ignore the recommendations of the Le Dain commission. Presently, Chief Coroner Cain (1994) recommends the decriminalization of simple possession of specific drugs.

Although Stevenson et al. (1956) and, more currently, Cain (1994), stress the need for more humane drug law reform, they also advocate stricter penalties for drug dealers. However, ethnographic and qualitative studies demonstrate that many people who use drugs also sell them (Matthews et al., 1995; Waldorf, Reinarman, & Murphy, 1991). The line separating drug users and drug dealers appears to be illusory. Therefore, harsher penalties for drug traffickers would be harmful for drug users in general. Furthermore, rarely is the organized drug trafficker charged and convicted. Rather, the burden of the trafficking law falls on poor drug users. This is consonant with the distribution of drug charges in Canada today.

Trebach (1990) has compiled a list of 12 drug commissions from the 1890s to 1989. Six are British, one Canadian (the Le Dain Report), and five are from the United States. All of the commissions have advocated humane approaches in relation to drug use and drug users. None recommended a "war on drugs." On addressing the first meeting of the Princeton Working Group on Alternatives to Drug Prohibition, Levine (1994) commented that
the "twelve great drug commissions" were all prudent, judicious, and restrained, and all 12 commissions have been ignored by drug policy makers (p. 211). Levine (1994) gave three reasons for advocating radical recommendations: First, previous recommendations that were prudent had been ignored by policy makers. Secondly, policy makers know where to get prudent advice. Finally, policy makers have not listened to prudent advice in the past (Levine, 1994, pp. 211,212).

Although Levine (1994) was commenting on drug commissions and drug policy recommendations, practical applications for programs are integral to drug commission reports. If we are to radically improve both the lives of drug users and society as a whole, the drug users' voices must be prominent. Therefore, Levine (1994) stresses the need to reject cautious models and to utilize radical approaches that will stretch the boundaries of drug research. Levine (1994) suggests that only when a large body of research favours the legalization of drugs will decriminalization advocates enter the mainstream. When drug commission recommendations and drug research become radical and visionary, the current status of drug criminalization will change. Most importantly, Levine (1994) wants to see drug research that is truthful about drug use and the harms of drug criminalization. Only then will radical changes occur for drug users and society as a whole. Unfortunately, Levine does not discuss who will fund this research.
Critical research has brought to our attention issues of race, class, drug legislation and civil liberty. Underlying all of the discussions of drugs is the issue of "morality," as the use of specific drugs is considered immoral. The temperance movement, the war on drugs and the current campaigns to criminalize tobacco in Canada reveal the underlying issue of morality. Boyd (1991) discusses how illicit drugs, including marijuana, cocaine and opiates, are associated with pleasure and with third-world nations; and licit drugs such as tobacco, pharmaceuticals and alcohol are associated with affluent Western nations. Using drugs for pleasure, as opposed to taking prescribed drugs for medical reasons, is considered amoral by much of Canadian society. The positive effects of drugs (see Alexander, 1990; Boyd, 1991; Hadaway, Beyerstein & Youdale, 1991; Henderson, 1993a, 1993b; Weil & Rosen, 1983) are rarely acknowledged in the "war on drugs" climate.

VI. A CRITICAL FRAMEWORK: SOCIAL CONTROL

As noted earlier, this thesis is informed by the work of early critical researchers who literally transformed the study of illicit drug use (see Becker, 1963, 1967; Gusfield, 1963; Lindesmith, 1965; Schur, 1962; Sutter, 1966; Winick, 1962). The movement away from perceiving the "addict" as a criminal and toward an examination of how legal and social conventions define the illicit drug user, both symbolically and directly, stems from their research. Later research, both Canadian and

Critical researchers acknowledge that "crime" is a political construct, where the state can choose to act, or fail to act, and where selective criminalization takes place (Tunnell, 1993). In North America the most dangerous drugs are legal. Tobacco and alcohol are more lethal than the more benign illicit drugs, such as marijuana, and both heroin and cocaine (Alexander; 1990; Boyd, 1991; Trebach, 1987; Weil & Rosen, 1993). Boyd (1986) questions the assumption that drugs are dangerous and notes the difficulty in defining the word "drug." He argues that drug use for pain is legitimized by the medical profession as long as they are prescribing the drugs, whereas drug use for pleasure is condemned. These contradictions and hypocrisies are explored by authors who advocate the decriminalization of narcotics (Alexander, 1990; Boyd, 1991; Trebach, 1987).

Critical research has also explored why Canadians appear to support the war on drugs, harsh drug legislation, increasing human rights infringements and government and police activity surrounding illicit drug use. Hadaway,
Beyerstein, and Youdale (1991) state that the "threat of drugs" is presented as so great that government intervention is perceived as "noble" (p. 184). Furthermore, illicit drug use is perceived as the cause of many social problems, including crime and family break-up. Therefore, society must be protected from illicit drug use, and drug users must be protected from themselves, through mandatory drug treatment or incarceration (Hadaway et al., 1992). This thesis examines the fallacy of the "threat of drugs," and proposes that "social control" has been, and continues to be, a central concept of analysis adopted by researchers examining the criminalization of specific drugs in North America and, more recently, when examining maternal drug use.

Edwards (1988) contends that the term "social control" is appealing because it can be utilized as a conceptual tool when analyzing relations between the powerful and powerless. In addition, the term gives a theoretical unity to a wide range of social institutions and practices (Edwards, 1988). All social measures which manage, contain, punish, repress, direct or redirect individuals or groups are forms of social control (Edwards, 1988). Cohen (1985) refers to social control as "the organized ways in which society responds to behaviour and people it regards as deviant, problematic, worrying, threatening, troublesome or undesirable in some way or another" (p. 1). Social control can be direct and explicit or indirect and implicit.
All drug use in North America is socially controlled, whether formally or informally (Erickson et al., 1992). Advocates of the criminal/medical model of addiction support the continued surveillance and management of illicit drug users (Klein, 1983). It is evident that the origin of both Canadian and U.S. drug legislation was fuelled by moralism, racism and economic concerns. The Chinese in Western Canada and the U.S., were perceived as an economic threat to white labourers after the completion of the railroads. In British Columbia, racism and economic fears directed at Chinese labourers culminated in a labour demonstration and riot in 1907. Drug legislation was subsequently proposed, even though there was no pharmacological evidence to support drug prohibition (Boyd, 1984; Green, 1986; Solomon & Green, 1988).

Early advocates of drug prohibition in the U.S. were concerned that black southerners be made to stop using cocaine (Musto, 1987), and that the Chinese in the west be made to stop using opiate derivatives (Morgan, 1978; Musto, 1987). Musto (1987) correlates the fear of southern blacks who used cocaine with the high levels of lynching, legal segregation and voting laws that contributed to their political powerlessness. Although there is no evidence that black southerners were participating in widespread cocaine use, racist fears culminated in the construction of punitive drug legislation that was intent on controlling a specific segment of the population -- black southerners. The public did not
oppose early drug legislation and the broadening of police powers. They saw early drug legislation as controlling specific problematic segments of the population, which in Canada were the Chinese labourer and opium smoker (Solomon & Green, 1988) and in the U.S. were southern blacks and western Chinese (Musto, 1987).

Solomon and Green (1988) state that there was an understanding that the original drug legislation in Canada would not be used against ordinary citizens. Middle-class Canadians were more likely to be addicted to patent medicines and products sold through the pharmaceutical industry than to opium. Drugs are most likely to be prohibited if they are associated with a disliked or powerless group (Hadaway & Beyerstein, 1987). By the 1920s, Chinese Canadians were portrayed in Parliament as spreading the disease of drug addiction throughout Canada (Solomon & Green, 1988). Stereotyping the drug user as "other" has been a successful technique in promoting more punitive drug legislation. Race, class and gender conflicts underlie North American drug legislation, and the aggressive social control of drug use has eroded the democratic structure of both Canada and the U.S.

The "war on drugs" mentality has contributed to the increased social control of drug users. Recently, the "war on drugs" has become a "war on women" (Bloom, Chesney-Lind, & Owen, 1994). Women who use illicit drugs are increasingly regulated and punished through legal sanctions and social
service and medical policies (Gómez, 1994; Humphries 1993; Humphries et al, 1992; Maher, 1992). The following chapter will continue to build on the concepts of both formal and informal social control of women who use illicit drugs, as well as nondrug-using women, in Western societies.
CHAPTER 3 - Theoretical Framework: Part Two

Introduction

This chapter continues to outline the theoretical framework for this thesis. The following sections link the critical perspective of drug use and social control with feminist research on reproductive autonomy and familial ideology within a historical context. Feminist and critical theories are examined relative to informal social control, sexuality, reproductive autonomy, mothering, familial ideology and the gendered nature of drug use.

I. A GENDER ANALYSIS

This chapter is informed by the wealth of critical research that preceded this study, as well as current feminist research that draws attention to the role of gender. As mentioned in the preceding chapter, the "war on drugs" climate has recently been interpreted as a "war on women" (Bloom, Chesney-Lind, & Owen, 1994). But critical research, rich in class and race interpretations, has failed to provide a gender analysis in relation to female drug use. Feminist insights regarding mothering, the family and reproductive autonomy have

"The nuclear family is perceived as the basic family form in society. " 'The family' is presented both in law and in popular culture as the basic unit in society, a sacred, timeless and so natural an institution that its definition is self-evident. Its privacy is sought to be protected and its sanctity proclaimed....The ideal family, despite the gender-neutral references to 'spouse' and 'parent' in legislation, is still taken to mean a social relationship, sanctioned by law and preferably by religion, comprising a male adult, female adult, and their biological or adopted children" (Gavigan, 1988, p. 293).
recently influenced discussions of illicit drug use. To fully understand female illicit drug use, including maternal drug use and cultural responses to it, a gender analysis is required. Therefore, this thesis draws from both critical and feminist theory as frameworks for examining female illicit drug use and maternal drug use, using a social control model of analysis.

Western feminists have developed varying theoretical perspectives and alternative research strategies, focusing upon how women define issues and experiences (Ahluwalia, 1990). In North America, from the early days of consciousness-raising in the 1960s, feminist research has emphasized the subjective experience of women, placing women at the centre of inquiry and rejecting the "experts' objective view" (Wolff, 1990). Feminist theory is both empirical and analytical (Simpson, 1989). It unites theory, resistance and praxis (Acker, Barry, & Esseveld, 1991; Ahluwalia, 1990) and attempts to create social change (Reinharz, 1992).

Many feminists emphasize "the importance of sex, race and class as factors which together determine the social construction of femaleness" (hooks, 1989, p. 23). Turpel (1953) notes that race, class and gender cannot be separated, for one cannot be experienced without the others. As will be argued in this thesis, women's experience of illicit drug use is mediated by their race, class and gender, in conjunction with the legal and socio-economic environment.
A feminist perspective facilitates linking research on illicit drug use and reproductive autonomy. Without a feminist analysis of the wider implications of legal, medical and social service policy, as well as an analysis of the regulation of female illicit drug users, the social and political implications are lost. Nonfeminist research has failed to provide adequate exploration of the effects of the legal, medical and social service professions' role in linking illicit drug use, reproductive autonomy and mothering.

II. LAW AND SOCIAL CONTROL A FEMINIST CRITIQUE

Social control has been, and continues to be, a central concept in many analyses of law and society, whether feminist or nonfeminist, critical or noncritical. At the same time, it is a concept that has been subject to extensive criticism by feminist researchers. The adoption of the "social control" construct for analyzing the regulation of women's lives, and especially the lives of women who use illicit drugs, is explored.

Feminists have noted and challenged specific sites of regulation and social control that are ignored by both critical and noncritical researchers. These sites are gender specific, centring on familial ideology and biological reproduction as the loci of social regulation.

In the early 1970s, feminists claimed that the social sciences were male-biased, value-laden and exclusionary of woman's experience. The separation of the private and public
spheres was not deemed natural by feminists, who perceived the private as a domain of oppression for women. They recognized gender inequalities and violence against women, and realized that women were subject to forms of social control that men did not experience, especially within the "private sphere." This motivated them to develop theory that acknowledged female experience and to challenge the faulty dichotomies present in much traditional social control theory. These sharply defined divisions were traditionally believed to be mutually exclusive and often their precise meanings have been ambiguous. Informal/formal, official/unofficial and private/public dichotomies have contributed to a lack of clarity in legal and social control theory.

Within the critical school, the feminist perspective grew out of a growing awareness of and concern about familial ideology and biological reproduction as the sites of formal and informal social control. Smart and Smart (1978) note that women experience social control in relation to their reproductive cycles, double standards of morality, social and legal subordination, the separation of the private and public spheres and the ideology of a woman's place as the private sphere (p. 3).

Some radical feminists7 contend that male biological

aggressiveness (Edwards, 1988) or patriarchy (Hanmer & Maynard, 1987; MacKinnon, 1983) is the locus of social control of women. Other feminists look for more complex understandings of the locus of social control (Brophy & Smart, 1985; Edwards, 1988; Gavigan, 1986; Petchesky, 1983; Smart, 1989). Some feminists have analyzed specific sites of social control, including rape, battering, sexual abuse and pornography. Others have looked at the institutions that perpetuate social control of women, including law, welfare, medicine and psychiatry. The relationship between informal and formal social controls is significant. Women cannot be understood only within formal models of social control.

The State and the Private Sphere

MacKinnon (1983) and other radical feminists view the law as an agent of male interests. However, Petchesky (1983) argues that MacKinnon's (1983) monolithic conception of the state as a tool of social control for all males is faulty. Socialist feminists claim that the state and the law do not act only in the interests of men, nor do men represent a monolithic force (Smart, 1989; Edwards, 1988; Smart, 1984; Brophy & Smart, 1985; Petchesky, 1983). However, the distinction between legal and male control must be understood (Smart, 1984). Patriarchy is not a unified institution. Like capitalism, it contains contradictions (Gavigan, 1986). The state does not have a monolithic unity of interests. Rather,
it is diverse and contradictory (Smart, 1989). The law is not always an instrument of control from above. For example, public opinion has shaped family law and abortion statutes (Petchesky, 1990; Smart, 1984; Brophy & Smart, 1985). The law is "refracted" and it has not developed in a simple linear progression. For example, the development of fetal rights has been legislated alongside legalized abortion (Smart, 1989).

Private/Public Spheres

Donzelot (1980) discusses the many ways in which the family has become aligned with the medical, psychiatric, psychological and psychoanalytical professions, which locate the family as a site of regulation and discipline. However, Donzelot fails to recognize capitalism and the family as sites of oppression for women. Bennett, Campbell, and Coward (1981) criticize Hirst (1981) for viewing the family as a solution to social problems rather than a site of oppression for women. In Canada, different forms of capitalist organization and social relations have transformed patriarchal relations (Chunn, 1995). These transformations have affected the family by privileging the nuclear family model and heterosexual marriage, the sexual division of labour and the notion of the private/public split (Chunn, 1995; Barrett & McIntosh, 1990). Feminists have argued that the home, the private sphere, is constructed by the state (Dahl & Snare, 1978). Dahl and Snare (1978) focus on state complicity in maintaining the notion of a private sphere. This sphere becomes a private prison for
women, for within the notion of the private sphere, conflicts and control become personalised rather than being linked to the larger social structure. The family is both an "ideological and economic site of oppression" (Smart, 1984, p. 10). Smart (1984) states that the illusion of the family as private, rather than public, is exposed when family breakdown occurs and welfare and legal intervention occurs.

Women are regulated outside of the criminal justice system through medical and social service policy. Both professions have incorporated assumptions about women's role in society. Women who do not conform to familial ideology are regulated and punished. The law also becomes an integral part of the regulation of women in the areas of medicine and social services by appropriating their categorizations and practices into its domain (Smart, 1989, p. 96). The law extends its authority through "new methods of application" of the creation of new terrains by medicine and social services (Smart, 1989, p. 96).

The social control of women through familial ideology and biological reproduction (sexuality, pregnancy, mothering) is significant in relation to women who use illicit drugs. The dominance of the nuclear family within legal and social policy tends to render all other family arrangements deviant in the eyes of family court and the criminal justice system. Early

*Familial ideology privileges the white, middle class, nuclear family form in both Canadian law and social policy within the "private sphere" (Gavigan, 1988).
research by Carlen (1976), Daly (1987), and Eaton (1983, 1985), demonstrates that the courts give primacy to and uphold the dominance of the nuclear family, thereby exercising their "overt" function of social control of women (Eaton, 1985). Outside of the criminal law, familial ideology also informs the decisions of social workers and medical professionals in the formation of policy and regulations.

The social control of women in Western societies has been carried out primarily through the regulation of sexuality, reproduction, mothering and family norms. All women are subject to these controls. But women who use illicit drugs have become the battlefield for the increased surveillance, control and punishment of all women who do not conform to dominant ideologies of mothering. The following sections will examine sexuality, reproductive autonomy, mothering and familial ideology.

III. SEXUALITY

Biological determinism has strong roots in Western thought and sees women as inherently inferior and closer to nature than men. Aristotle thought that women were incomplete men and Locke believed that women were naturally dependent on men. These traditional assumptions evolved into scientific truths after Darwin introduced his theory of natural selection (Sydie, 1987). Women's bodies have often been viewed by social scientists as the site or cause of deviance. Criminological, medical and psychiatric research has focused on the
"differences" between women and men. These differences, both biological and psychological, have been perceived as the cause of specific deviant behaviours or tendencies. Women's reproductive capacity (menstruation, pregnancy, lactation, menopause) has been the site of many unitary causal explanations of behaviour and crime (Jaggar, 1992). Historically, women - and especially criminalized women, poor women, and women of colour - have been portrayed by medical, legal and social service professionals as amoral. Due to their capacity to reproduce, they have been portrayed as closer to nature, less rational and less morally responsible for their behaviour (Smart, 1989). In contrast, men are perceived as cultured and rational. Central to Western thought is binary thinking, which incorporates contradictory sexual images of women: good/bad, madonna/whore (Klein, 1973). Deviant women are separated from "good" women through laws that seek to control their behaviour (Smart, 1985).

Central to the eugenics movement in Canada was the control not only of race and class, but also of morality and sexuality, as defined by white, male, middle-class Protestant professionals (McLaren, 1990). In the U.S., black women were used as breeders in the time of slavery. This objectified them as less than human. The legacy of this ideology can be seen today in pornographic portrayals of black women as "objects" and "animals" (Collins, 1990, p. 170). Exploring the role of black women as commodities for white men and the historical
roots of this premise, hooks (1992) critiques the image of the black woman as sexually uncontrollable, savage and animal-like that has been portrayed by the medical, legal and social work professions in justifying forced sterilization. These same misapplied attributions are assigned to black women in the United States who use crack cocaine.

A major influence in changing Canadian perceptions regarding drug use and sexual immorality in the early twentieth century was Emily Murphy, a police magistrate and judge for the juvenile court in Edmonton. In The Black Candle she reinforces racist fears of people of colour and the myth of white women being sexually corrupted by foreign men (Murphy, 1922). Murphy wrote that drugs led to moral and sexual degeneration, crime and physical ruin. Her villains included Chinese and black pushers motivated by greed and lust for white women (Murphy, 1922). Murphy had no accurate knowledge of the pharmacological properties of narcotics. Nevertheless, her moralistic, sensationalist and racist style continues to be reproduced by the media and by social researchers in North America.

Since the criminalization of narcotics in Canada in the early twentieth century, women who use illicit drugs have been portrayed as amoral and sexually promiscuous (see Kantor, 1978; Stevenson et al., 1956). Studies of female drug use demonstrate an interest in women's sexual lifestyle that is rarely extended to male drug users. Inciardi et al. (1993)
claim that "one effect of all forms of cocaine, including crack, is the release of normal inhibitions on behavior, including sexual behavior" (p. 96). They also claim that the pharmacological component of crack results in compulsive use and "a willingness to obtain the drug through any means" (p. 97). Further, they state that many women addicted to crack will have "any manner of sexual activity, under any circumstances, in private or in public, and with multiple partners of either sex" (p. 96). Other researchers argue that "crack addiction totally overpowers a mother's instinct to protect her unborn child" (Peak & Papa, 1993, p. 249).

Rosenbaum, Murphy, Irwin, and Watson (1990) claim that the media present a picture of mothers who use crack cocaine as a threat to the moral character of society, as they violate the "two cultural mores that women are supposed to protect: sexual virtue and motherhood" (p. 2).

In contrast to the myth of increasing female promiscuity and illicit drug use, the Macdonald, Waldorf, Reinarman, and Murphy's (1988) study of 228 heavy users of cocaine in the U.S. demonstrated the diversity of sexual responses to cocaine use. It appeared that men reported more sexual enhancement from cocaine than did women. However, the heavier the cocaine use, the more negative was the effect on one's sex life (Macdonald et al., 1988). In interviews of female crack cocaine users, Rosenbaum et al. (1990) found that cocaine use lowers sexual desire in women, and claimed that the women
interviewed felt that male researchers have tended to exaggerate the importance of sex in their studies (p. 4.). Finally, a recent British Columbia study of recreational and addicted cocaine users noted that addictive cocaine use "was frequently associated with a lack of sexual ideation and behaviour" (Matthews, 1994, p. 24).

Henderson’s research on young women (304) and men (70) who used drugs (ecstasy, LSD, amphetamines) recreationally, and were part of the "dance and drug" scene in Manchester notes that sex was not a primary goal of the women or men, and "lack of active interest in sex often appeared to accompany periods of heavy club-going and ‘dance drug’ use" (Henderson, 1993b, p. 10). A re-evaluation of the persistent theme linking sexual immorality and female illicit drug use is clearly warranted.

The discussion of sexuality and women drug users is linked to the literature on pregnancy and mothering (Rosenbaum et al., 1990). Pregnancy and single-parent status of women who use illicit drugs are of particular concern to legal, medical and social service professionals (Streissguth, Grant, Ernst, & Phipps, 1994; Fricker & Segal, 1978; Stone, Salerno, Green & Zelson, 1971; Stevenson et al., 1956). Prosecutors claim that women who use illicit drugs have multiple partners and violate family norms (Gómez, 1994). Studies which evaluate techniques of preventing further pregnancies carry the underlying message that sexual promiscuity is rampant among
women who use illicit drugs. The threat to the reproductive autonomy of women who use illicit drugs has negative implications for all women.

IV. REPRODUCTIVE AUTONOMY

Feminists have argued that women are subjected to specific forms of social control due to their capacity to become pregnant. Traditionally, pregnancy was discussed as an individual event. However, recent discourse has broadened our concept of reproduction and the social constraints surrounding it. Maternal drug use has recently become controversial. Mothers have been detained, arrested and subjected to medical interventions due to their status as suspected illicit drug users.

Historically, the realm of reproduction was woman-centred. Female healers and midwives attended to women’s reproductive needs (Ehrenreich & English, 1973). Midwifery was a holistic practice that supported the mother and celebrated birth (Martin, 1992). Pregnancy and birth were not "synonymous with illness" (Burtch, 1994, p. 55). Midwives have traditionally been the "guardians of normal birth."

During the late nineteenth and early twentieth centuries, the newly established medical profession strengthened its fragile position by defining pregnancy and birth and appropriating them from lay women, traditional midwives and healers (Ehrenreich & English, 1973; Oakley, 1984). Legislation was passed in most of Canada during the twentieth
century rendering the practice of midwifery illegal. Pregnancy
and birth were now defined in Canada as medical events that
required doctors, nurses and specialized technology (Burke, 1994). Lobbying efforts, medical "science," and the policing
of rebellious doctors and deviant or "immoral women" led to
the medical profession's acquisition of control over many
aspects of women's lives (McLaren, 1978).

Women were considered ignorant in the areas of pregnancy,
childbirth and child care. This justified the surveillance and
control of these areas by the newly established medical
profession (Arnup, 1994; Oakley, 1984). The emergence of
antenatal care in the early twentieth century shaped women's
experience of pregnancy, birth and mothering (Arnup, 1994;
Oakley, 1984).

The obstetrical pursuit of more and more knowledge about
the fetus in utero is an important aspect of the medical
profession's claim to legitimacy. New antenatal interventions
have allowed the obstetrical community to acquire information
about the fetus without using the mother as intermediary
(Oakley, 1984). The mystification of pregnancy by the male-
dominated medical profession and the emergence of reproductive
technology have limited women's knowledge of their bodies
(Smart & Smart, 1978). Mothers lack information about their
pregnancies, and the period before birth has been opened to
medical scrutiny and expertise.
In Western societies, the rise of medicine and psychiatry in the late nineteenth and early twentieth centuries contributed to the concept of biological explanations for women's behaviour. Women's capacity to reproduce was viewed as the site of all physiological and psychological explanation (Mitchinson, 1988). The history of the medical treatment of women in Canada emphasizes the continuing struggle by women to define their own experience of birth, menopause and menstruation, and to rebel against the medical profession's moral stance on their proper role in the family and in society (Mitchinson, 1991).

Birth Control and Fetal Rights

Eugenics was closely linked with the medical profession in Canada. The sterilization of racial minorities, the mentally incompetent, the deviant and the poor was widely advocated from the late 1800s through the middle of this century (McLaren, 1990). Central to the eugenics movement was the control of race and class, and morality and sexuality, as defined by white, male, middle-class, Protestant professionals (McLaren, 1990). The eugenics movement also has had a racist edge in the U.S., where First Nations, Chicana, Puerto Rican and black women have been sterilized in disproportionate numbers (Fried, 1990; Davis, 1981). Currently, new forms of contraception are used to limit reproduction. A California judge ordered that a mother charged with child abuse be implanted with Norplant (a controversial contraceptive which
lasts for five years and must be surgically placed under the skin) as a condition of her probation (Mertus, 1991).

Prior to the nineteenth century, women in Canada were not restricted from obtaining birth control or abortion before quickening (Brodie, Gavigan, & Jenson, 1992; McLaren, 1990). Even though the use of birth control and abortion were criminalized in the nineteenth century, Canadian women continued to obtain birth control and abortions illegally. The use of birth control and abortion was legalized in Canada in 1969; however, at that time abortion was not a woman's right. Rather, it became a medical matter, where Therapeutic Abortion Committees decided which women were eligible (Brodie, Gavigan & Jenson, 1992). Currently, Therapeutic Abortion Committees no longer exist in Canada, and women have improved access to abortion.

Since the advent of legal abortion in Canada, the fetal rights movement has gained considerable leverage. The representation of the fetus as a person with sovereign rights has led to a questioning and erosion of women's rights, and the fetus and the mother are viewed as adversaries. Brodie et al. (1992) note that "there is an obvious political imperative to protect the foetus against the destructive impulses of the pregnant woman" (p. 83).

However, the characteristics that compel us to recognize "personhood" do not appear until long after birth. "Fetal personhood" is a decision, not a medical or legal discovery
The medical model of birth and of the female body has led to the perception of the uterus as a machine, the woman as a labourer, and the baby as the product. Martin (1987) states that doctors are concerned with fetal outcome, not with the mother and the delivery (Martin, p. 64). As discussed earlier, the late nineteenth century saw a revolutionary transition from the care of the mother by other women, healers and midwives (based on her subjective knowledge of her pregnancy and health) to the obstetrical pursuit of more and more information, culminating in contact with the fetus with no need for the mother as intermediary. New technologies facilitating contact with the fetus have led to an extension of the moment of "personhood" (Oakley, 1984). Legal and medical discourses in relation to the fetus legitimize their hidden assumptions about women and mothering through science and its "claim to truth" (Fitzgerald, 1993, p. 3). And "the boundary between what constitutes the 'good' mother and the 'bad' mother has become clearly delineated in terms of a medical-scientific definition" (Fitzgerald, 1993, p. 18).

As well, the image of the fetus as separate from the mother, documented in medical textbooks, has emerged as a visual representation of life and death. Anti-abortionists were quick to recognize the potential of the visual representation of the fetus (Petchesky, 1990). Consequently, fetal personhood has become a symbol for the anti-choice

The impact of fetal rights is highlighted in Kolder, Gallagher, and Parson’s (1987) documentation of court-ordered obstetrical interventions in the United States. They discovered that 81 percent of court-ordered interventions directed at pregnant women were for black, Asian or Hispanic women; 44 percent were unmarried, and none were private patients (p. 1192). The symbolic importance of the fetus, and court-ordered Caesareans, convey important legal and moral messages to women concerning their status in society. Medical technology and prenatal medical interventions have advanced fetal rights, and "spurred a resurgence of powerful, largely unacknowledged social attitudes in which pregnant women are viewed and treated as vessels" (Gallagher, 1989, p. 1988).

The controversy emerging over court-ordered interventions and fetal rights is also noted by Maier (1992) in her case study of "Baby R" in Vancouver, B.C.. Maier (1992) examined court-ordered caesareans and developed the term "reproductive violation," which includes forcible confinement and reproductive violence (p. 84). The criminalization and imprisonment of pregnant women in the U.S. who use illicit drugs (in order to protect the fetus from exposure to maternal drug use) falls under Maier’s category of reproductive violation.
According to Shaw (1985), if "the mother decides to carry a fetus to term, she incurs a conditional prospective liability toward her fetus that ripens at live birth" (1985, p. 314) and she claims that the child should be able to sue the mother for "wrongful prenatal care." Robertson (1989) contends that incarcerating pregnant women is preferable to incarcerating women after birth, for fetal harm may be avoided. Furthermore, he argues that incarceration will be cheaper in the long run, for it will lower the cost of caring for the disabled children of drug addicts (Robertson, 1989). Logli (1990) agrees that "once a pregnant woman has abandoned her right to abort and has decided to carry the fetus to term, society can well impose a duty on the mother to insure that the fetus is born as healthy as possible" (p. 26).

In Roe v. Wade (1973), the United States Supreme Court noted that the state's interest became compelling when the fetus became viable, or able to live outside the mother's body. In the landmark decision in Morgentaler v. The Queen (1988), it became clear that all of the Canadian Supreme Court judges involved were committed to "state interest in the fetus...if not full legal personality" (Brodie, Gavigan, & Jensen, 1992, p. 127). Canadian Justice Wilson states that the state may be compelled to have an interest in the fetus depending on its gestational age. The Law Reform Commission of Canada (1989) states that women have a moral obligation to their fetus to avoid harm, and the "foetus merits at least
some protection, not necessarily of the same order as that accorded to those already born, but of a kind increasing as it develops" (1989, p. 7).

Fetal rights legislation raises the question of fetal harm and protection. As previously mentioned, often the fetus and the mother are viewed as adversaries. With the advancement of reproductive technology, the moment of fetal viability is continually extended and women's rights diminish accordingly. The representation of the fetus as a person with sovereign rights has led to a questioning and erosion of women's rights. The arguments for legal personhood of the fetus have contributed to expanding state control of all pregnant women and of birthing choices (Gallagher, 1989).

It is often assumed that "protective" fetal legislation will enhance the health of the developing fetus and the pregnant mother. However, Smart (1989) notes that health promotion is not "intrinsically good." Rather, it can have very serious ramifications for women and infants, especially when women's bodies are constructed as "central to the health of others" (p. 99). Medical concern with fetal health and healthy pregnancies, which is constructed as a desirable goal, can be "transposed into oppressive forms of legislation which assume the terminology of benevolence and public health" (Smart, 1989, p. 98). The focus on fetal health has led to discriminatory practices against all women, and especially women who use illicit drugs. Nondrug-using women in North
America have been subject to court-ordered obstetrical interventions, urine testing for drug use and instructions by health professionals that have little to do with the needs of the mother. Seeing women's bodies as "central to the health of others" can lead to discriminatory practices against women (Smart, 1989, p. 98).

The focus on deviant pregnant women distracts society from addressing such issues as racial and class bias, "fetal protection" policies, the U.S.'s poor maternal health and infant mortality rates (which are the highest among all Western nations) and the lack of services and resources "that enable women to have healthy babies" (Chavkin, 1992, p. 200). Nsiah-Jefferson (1989) argues that poor women and women of colour have always been held personally responsible for poor reproductive outcomes. Furthermore, nine months of antenatal care during pregnancy "cannot offset years of poor health" (Mitchinson, 1988, p. 259).

The role of the medical profession as an agent of social control "and arbiter of reproductive behavior" (Stephenson & Wagner, 1993, p. 174) has been challenged by critical and feminist social researchers. Historically, and in contemporary society, pregnant women have been instructed on how to behave and restricted from certain activities. Women have been told to avoid exercise, or to be sure to exercise daily. They've been instructed to have an alcoholic beverage before bedtime to induce sleep (in the 1950s), or to abstain from alcohol.
They've been ordered to eat well, to reduce weight, to take vitamins, to take drugs prescribed by their doctors (including Thalidomide, phenobarbital and amphetamines). Still, we rarely perceive doctors as hazardous to pregnancy. Rather, the mother is perceived as a source of harm (Rothman, 1989). Pregnant women are presented with obligations for every waking moment of their day (King, 1989), and these obligations rarely reflect their desires.

According to Faith (1993), "medicine provides the scientific framework within which female subordination is ideologically justified and law supplies the mechanism" (p. 45). For women who use illicit drugs in North America, the arm of the law "retains its 'old' power... whilst exercising new contrivances of power in the form of surveillance and modes of discipline" (Smart, 1989, p. 17). These "contrivances" include the medical and social services professions. Although women who are suspected of illicit drug use suffer from these new controls, all women, to some extent, have been subject to social service, legal and medical regulation in Western societies since the late 1800s (Oakley, 1984).

Feminists conclude that the criminalization of pregnancy (Callahan & Knight, 1992; Chavkin, 1992; Humphries et al., 1992; Maher, 1992; Mariner, Glantz, & Annas, 1990) and emerging fetal rights have culminated in a situation where the well-being and security of women's bodies is legally and
physically challenged (Gallagher, 1987, 1989; Martin, 1987; Oakley, 1984; Petchesky 1990).

In addition, Oakley (1984) states that motherhood has been co-opted by the scientism of medicine. Women who use illicit drugs are often challenged by the legal, medical and social service professions once their children are born, for it is thought that illicit drug use equals poor parenting, which places children at risk.

V. MOTHERHOOD

Motherhood is central to the debates surrounding prenatal drug use, abortion rights, reproductive technology, maternity leave and daycare benefits. What constitutes mothering changes historically, and from culture to culture. Once thought to be an unchanging, universal, instinctual response, Mothering has been revealed by feminists as a social construct, rather than a biological imperative (Glenn, 1994). Until recently, most Western research on mothering projected the concerns and experiences of white, upper-class women (Collins, 1994). Currently, many critical feminists have begun to examine not only the gender bias of research on mothering, but the race and class biases as well.

Adrienne Rich (1986) examines the concept of mothering as both experience and institution. She claims that motherhood can be a powerful and positive experience for women, but has been co-opted by complex interlocking forces - medicine, law, culture and male expertise - which serve to control women’s
bodies and minds. Rich (1986) also discusses the successful struggles of women to resist outside definition and controls by patriarchal power.

Although most feminists currently portray mothering as a social construct, many disagree about social responses to mothering, and about women's responses to mothering. The ideology of mothering⁹ that pervades Western societies has made the actual unpaid work of mothering invisible. Since the Industrial Revolution, mothers have been romanticized as the givers of life and the caretakers of society's children, self-sacrificing and powerful in their maternal love. However, Kaplan (1994) notes how ideologies accommodate contradictory elements; thus women are also perceived as domineering, destructive, subordinate and powerless against the forces of nature and instinct. Mothers are both feared and revered, and perceived as objects rather than subjects (Thurer, 1994).

During the Industrial Revolution the roles of women and children changed. Children were no longer economic contributors to the family. Rather, they were perceived as dependants in need of constant care and protection (Glenn, 1994; Mandell, 1995). Women were perceived as fit for the job

⁹"The meanings and practices of motherhood, vary enormously through history, across cultures, and within the same culture--indicating that these 'natural' realms of human experience are incessantly mediated by social praxis and design" (Petchesky, 1990, p. 9). By "depicting motherhood as natural, a patriarchal ideology of mothering locks women into biological reproduction, and denies them identities and selfhood outside mothering" (Glenn, 1994, p. 9).
of caring for the household and children due to their innate moral purity, self-sacrificing nature and lack of intellect (Glenn, 1994). Child rearing and the production of children became a national and moral duty. However, in order to fulfil their duties properly, mothers needed to be instructed (Arnup, 1994; Davin, 1978). It was believed that mothers' ignorance led to social problems; therefore, classes were set up to educate mothers on proper hygiene and parenting skills. Rather than expanding social and medical services to ameliorate the myriad social problems related to the Industrial Revolution (such as high unemployment, lack of housing, poor working conditions and insanitary conditions), it was easier, cheaper and consistent with ideological hegemony to blame mothers (Arnup, 1994; Davin, 1978).

Problems related to poverty were no longer defined as social; rather, public health and medical care were promoted as the cure for all family ills. With the advent of the public health and maternal health movements, motherhood has become a medicalized domain. Medical services that emphasized the surveillance of children, rather than care, and the technicalization of love, rather than the relationship between infant and mother, have become the norm during the twentieth century (Oakley, 1986).

The reality of mothering for most women, and especially for poor women and women of colour, has had little to do with virtue and caretaking of the future of society. Rather, it
consists of long hours of unacknowledged and unpaid work and total responsibility for the care of dependants and household. Although some mothers are able to stay at home full time with their children, most participate in outside employment (Segura, 1994). White middle- and upper-class women are able to escape the drudgery and physical labour of mothering by hiring women of colour as domestics to care for their children. Therefore, women of colour are denied relationships with and care of their own children as they work outside of the home in order to financially support their own families (Collins, 1994; Gupta, 1995). "Diverted mothering" can be traced historically to slavery times (Wong, 1994, p. 71).

Although the ideology of mothering that portrays women as giving, pure and maternal permeates Western societies, women of colour and poor women are not enveloped by this mythology. Rather, they are located within the contradictions of the ideology of mothering, which perceive them as incapable of nurturing and socializing children (Gupta, 1995), sexually promiscuous, having one baby after another (Solinger, 1994), and savage and animal-like (hooks, 1992). What is hidden by the ideology of mothering is the struggle by women of colour and poor women to have control over their own bodies, to have children, to keep the children they do have and to protect their children from dominant ideologies that render their culture invisible (Collins, 1994). Slavery, the eugenics movement, forced sterilization and contraception, residential
schools, child apprehension and medical isolation of children diagnosed with Neonatal Abstinence Syndrome have served to prevent poor women and women of colour from having and keeping their own children.

Often researchers and the media have constructed negative images of "deviant mothers" who use illicit drugs (see Cain, 1994; Inciardi et al., 1993; Logli, 1990; Robertson, 1989; Shaw, 1985; Steinberg, 1994; Stone et al., 1971; Tait, 1996; Williams & Bruce, 1994). They are portrayed as immature, out of control, deviant, unfit mothers and a risk to their children (Taylor, 1993). Rosenbaum et al. (1990) note that the media has portrayed women who use illicit drugs as failing in their roles as mothers.

Due to their suspected sexual immorality and their imagined compulsion and relentless drive to obtain their drug through any means, women who use illicit drugs have been portrayed as deviating from traditional gender roles, especially motherhood. However, Rosenbaum et al.'s (1990) study on women who use crack acknowledged that these mothers share the parenting values of nondrug using mothers. Research of female narcotics users has noted that these mothers share the same attitudes and hopes in mothering as the rest of society (Taylor, 1993). Nevertheless, the stigma and stereotype of "bad mothers" and "loose women" continue to colour the discussion of maternal drug use.
Oakley’s (1992) study of 509 women in England emphasizes the social context in which most women experience their pregnancy, birth and mothering. Women spoke about the bluntness of an antenatal care system that emphasizes clinical surveillance and control rather than woman-sensitive care; the unwillingness of fathers to take emotional and physical responsibility; lack of money and decent housing; social isolation and stress; mothering as hard, caring work (Oakley, 1992, p. 228).

Oakley concludes that women’s bodies are objects of medical science, and that motherhood as a moral idea is very different from motherhood as a social reality. The women involved in Oakley’s study were not identified drug users; rather, they were pregnant women who had previously delivered a low birthweight infant. Nevertheless, the concerns of these mothers appear to be similar to those of women in North America. Women are given total responsibility, and held personally responsible, for the outcomes of their pregnancies, regardless of social and environmental factors that have negative effects on pregnancy outcomes and mothering in general. In the face of an ideology of mothering that ignores the social reality of women, and especially of poor women, women who use drugs are perceived as especially deviant.

VI. THE FAMILY

In order to further understand mothering and the current and historical position of women in society, one must examine the family and women’s position within it. Women who use illicit drugs often come into contact with the criminal
justice system and with medical and social services. These agencies often make negative decisions based on the perceived lack of "family" in the lives of illicit drug users. In nonfeminist research, the Western family structure (the nuclear family) has been perceived as a natural social institution that meets the basic needs of society's members. In contrast, critical researchers argue that the construction of the family is historical, and social and economic factors influence and shape the structure of the family as well as the power relations between the individuals within it. Furthermore, families differ according to cultural and ethnic backgrounds. The ideology of the nuclear family model is entrenched in legislation and policy, even though this family form represents a small percentage of the population.

Barrett and McIntosh (1990) contend that the family maintains class and gender inequality. The family is both an economic and a social institution, and must be perceived as an ideological construction (Barrett & McIntosh, 1990). The concepts of ideology and women's place are explored by McIntosh (1984), who states that the "family is central to any exploration of the relations between the modern state and civil society in Britain" (p. 204). McIntosh (1984) identifies four different views: the interventionist state expanding its activities; the family as bastion against state control, the family as functional to the state's and economy's needs, and the family as serving specific interests of different groups.
McIntosh notes that the home and women's roles within it are separate from the public world of men, and unequal and subordinate (McIntosh, 1964). She claims that the state plays a key role in maintaining the ideology of the family as "intact and ideal," which sanctions the heterosexual nuclear family model as the most legitimate and enduring one. The ideology of the family "provides a very important unifying image of the nation state" (p. 237).

Chunn (1988) illustrates how "socialized" legal coercion was applied to deviant families by early family courts in order to persuade them to adopt middle-class family patterns during the inter-war years (1920-1940) in Canada. Chunn also discusses how Ontario's working and dependent poor often sought out services, and how "poor families and, in particular, poor women were both empowered and oppressed, active and acted upon, by the new domestic relations tribunals" (p. 152). Chunn notes that the (liberal) state has always intervened in the "private" sphere but the "degree and mode" of state intervention changes according to the type of liberal state constructed. The "emphasis of family court personnel on privacy obscured the reality that the state--in the form of 'socialized' legal coercion--was more intrusive than ever before in regulating the intra-familial relations of the working and dependent poor" (Chunn, 1988, p. 152).

Historically in Canada, families were not homogeneous; rather, high child mortality rates and spousal deaths caused
family disorganization, and family diversity was the norm (Gee, 1995). One-person households accounted for 25 percent of all households in Canada in 1991 (Gee, 1995, p. 94). In the same year, 40 percent of all marriages in Canada were found to have ended in divorce (Gorlick, 1995, p. 211), and single-parent families comprised about 13 percent of all families (Gee, 1995). Two characteristics of single-parent families are their low economic status and the noninvolvement of fathers (Gee, 1995). About 45 percent of single-parent families (mostly headed by women) in Canada are poor (Gorlick, 1995, p. 214), and recent immigrants are more likely to be poor than other Canadian families. Gee (1995) suggests that poverty in Canada is defined increasingly by two characteristics - race and gender (pp. 98,99).

Much of the discourse surrounding the development of the family and the role of women in the family centres on the nuclear family with European roots, which developed during the Industrial Revolution. Women of colour have argued that European tradition and the nuclear family exclude kinship roles and extended families. They point out that they are often denied the right to live in a family context in Canada. Immigration laws, head taxes, educational and social welfare policy, internment camps and genocide have contributed to the disintegration of their families. For example, colonial domination led to a policy of the cultural genocide of First Nation families in Canada, which in turn led to "economic
devastation, poverty, and social disintegration" (Gupta, 1995, p. 145). The removal of First Nations people to reserves and the removal of their children, first to religious-based residential schools and more recently by the child welfare system, has devastated the traditional family form (Gupta, 1995; Monture, 1989, Turpel, 1993).

During the late 1800s, Chinese men were admitted to Canada to complete the railways. However, Chinese women were excluded due to the costly head tax enacted in the Chinese Immigration Act. South Asian women were not allowed to enter Canada until 1911, and then only as wives. Domestic workers, predominately Caribbean women and Filipinas, have been allowed to enter Canada to do contractual work. Often they leave their families behind and work at "mothering" white, Canadian-born families (Gupta, 1995). When women immigrants are allowed into Canada, they are generally wives or dependents. When they arrive on their own, they have generally been slaves\textsuperscript{10} or, more recently, domestic workers or seasonal farm workers (Gupta, 1995). Although the Canadian government has, in many instances, systematically prevented the formation of families for people of colour, family formations have emerged. The family is often viewed by people of colour as a site of resistance against racist oppression (Lees, 1986; hooks, 1990, 2002).

\textsuperscript{10} Contrary to popular belief, slavery did exist in Canada, specifically in what became Quebec, Nova Scotia, Ontario, and New Brunswick between 1629 and 1834" (Gupta, 1995, p. 160).
The home was a place where affirmation, nurturing and healing took place (hooks, 1990). Nevertheless, the family is a social construction, and for many people there is no haven from the oppressions of society (Glenn, 1994; Gavigan, 1993).

The structure of the family is political. Women’s position within the family, and government’s failure to recognize kinship ties and extended family, have led to oppressive policies in North America. The traditional roles of women within both African-heritage and First Nations families differed from those embodied in the European model. Generally, they enjoyed more equality with men and more active participation in their communities (Queen, Habenstein, & Quadagno, 1985) than did European women (excluding the aristocracy) prior to the Industrial Revolution.

As Canada moved into the Industrial Revolution, the family and household were transformed from the social centre, and equal workplace, to a private sphere that separated women’s and men’s roles. Simply stated, men became the breadwinners and women the homemakers. Women were given total responsibility for raising their children. Children were perceived as "sentimental love objects," rather than economic contributors to the household, and romantic love in marriage was stressed as this new family ideology emerged (Mandell, 1995). Women who worked, or who otherwise did not fit within the new ideology, were perceived as unfit mothers in need of guidance from social and medical agencies.
VII. SOCIAL SERVICE INTERVENTION

Women in Canada who use illicit drugs are often challenged by social services agencies in relation to their mothering. As Cain (1994) points out single mothers who use illicit drugs are much more likely to come into contact with social services than are men. Many social service professionals equate illicit drug use with poor mothering (Humphries, 1992; Maher, 1992; Maier, 1992), which places children at risk at birth or later in life. In addition, social work agencies have expanded their control to define and act in specific cases where fetal harm is suspected (Gómez, 1994). The apprehension of children of any age, and the reduction or denial of services, are interventions used by social workers to regulate women's behaviour. This section will review the literature on the emergence of social services in Western societies and the social control of poor and "undeserving" women. The regulation of women who use illicit drugs, and the integration of social services, the law, and medicine will also be examined.

Historically, the growth of social welfare legislation has been linked to patriarchy. Drawing from O'Brien (1981) and Eisenstein (1979), Ursel (1992) adopts a dual-systems theory that identifies reproduction and production as "equally fundamental and interdependent social relations." Ursel claims that the purpose of patriarchy is the control of reproduction, defining reproduction as "the production of human life, which
involves three processes: procreation, socialization and daily maintenance.

Theorizing about the relationships between reproduction, production, patriarchy and the state Ursel (1992) describes the historical changes that transformed patriarchy in Canada. Communal patriarchy was replaced by familial patriarchy. Later, social patriarchy emerged, as women - who do the reproductive work - were excluded from making decisions about this work. The shift from the individual man (the head of the patriarchal household) to social patriarchy increasingly linked women and children to the state. As the state became more involved in the family, legislation related to protecting children and parental fitness was enacted. In contrast to familial patriarchy, where control and authority over woman and child was played out in the home, social patriarchy in the modern welfare state controls women and children through laws, institutions and the state (Ursel, 1992).

The expansion of the welfare state in Western societies began in the early 1900s. Social services and the regulation of families emerged in Canada during this era. Chunn (1988) describes this time as "a major socio-legal transformation in...Canada" (p. 137) and other Western industrial countries. In Canada and the U.S., the largest expansion occurred in the late 1930s and in the 1960s. Historically, the origins of the welfare state have primarily been in a "a white set of
political, economic, and familial assumptions" (Gordon, 1990b, p. 25).

Until recently, most studies of the welfare system in Western societies did not include an analysis of gender, though class analysis was eventually introduced (see Piven & Cloward, 1971). The lack of gender analysis biased early studies of the welfare system by obfuscating the underlying discrimination in policy decisions and practice (Gordon, 1990b).

**Maternal Feminists**

Maternal or "first wave" feminists (during the last quarter of the nineteenth century and early twentieth century) promoted early welfare formation and policy (Sapiro, 1990, p. 36). Thus, the welfare state structure in Western societies was influenced by women who acted on behalf of other women less fortunate than themselves by shaping policy to regulate the "private" sphere of the family (Chunn, 1995; Gordon, 1990b; Sapiro, 1990). First-wave feminists in Canada were concerned with what they perceived as the disintegration of family values through urbanization, and they sought to reinforce the role of motherhood and to keep the family intact (Ursel, 1986). In order to create a social platform for their concerns, maternal feminists relied on prevailing beliefs about women's innate knowledge, virtues and moral qualities derived from their biological function as mothers (Glenn, 1994). These claims to virtue and morality were the very
ideology that justified women's subordination (Glenn, 1994). Maternal feminists fought for many reforms that benefited mostly middle- and upper-class women which reflected their own social and economic status. These included divorce, custody and property law reform (Chunn, 1995). Chunn (1995) reveals how poor and marginal women benefited from child and family welfare laws concerning support, maintenance and guardianship (Chunn, 1995). However, women who applied for mothers' allowance, custody or maintenance were judged for "moral fitness." Therefore, only the "deserving" received assistance, and the "undeserving" were punished through child apprehension, denied assistance and criminal prosecution (Chunn, 1995, p. 191). White, working-class widows who maintained their moral virtues were the deserving poor. Immigrant women, and unwed mothers were "undeserving" (Thane, 1978). Gordon (1990b) points out that in practice both groups were treated similarly, since all female-headed families were perceived as threatening morality.

Early welfare policy supported independence and individualism in men, and dependence and reliance on paternalism in women (Sapiro, 1990). Welfare policy for women was granted to benefit them in their role as mothers and wives. The male-headed nuclear family was the norm from which welfare policy emerged. Welfare policy allowed women to "care" for their families, in contrast to "providing" for their families (Sapiro, 1990). Welfare policy reinforced the
subordination of women in the domestic sphere and functioned to render invisible women's unpaid labour in the home, in essence supporting the family wage (Nelson, 1990).

Although welfare policy assumes that women and children should rely on men for financial support, policy aimed at enforcing divorced men to pay child support has been applied half-heartedly, if at all, in both the U.S. (Sapiro, 1990) and Canada (Chunn, 1995). Historically, welfare policy has maintained a double standard of welfare provision for men and women. Men were offered Workmen's Compensation and women were offered mothers' allowance in Canada (Chunn, 1995), and Mother's Aid, or AFDC, in the U.S. (Nelson, 1990). Mink (1990) claims that welfare entitlements were based on "mothers' needs" and "women's economic dependence on men" (p. 113). Welfare policy entrenched race and gender distinctions in entitlements. Eligibility criteria authorized the regulation of women's personal lives and supported the assimilation of "subordinate" races into the welfare system (Mink, 1990).

Through political activism, white middle- and upper-class women campaigned to help less fortunate women. However, historically these women were not contesting women's status in society. Rather, they supported domestic policy wherein women belonged in the home (Chunn, 1995; Baker, 1990; Gordon, 1990a;1990b). Women relied on their role as domestic caretakers of the moral fabric of society to promote political changes that would increase government involvement in social
welfare (Baker, 1990). Although welfare policy functioned to subordinate poor women, it also clearly helped many. The shifting relationships surrounding welfare benefits for women exemplify the relationships entrenched within welfare policy. Aid to mothers is not a "right"; women do not believe that they have a "claim" to benefits, as a man had when claiming workman's compensation. Rather, women arrived at welfare agencies hoping that the effects of poverty or abuse by husbands would be lessened (Gordon, 1990a). Welfare agencies have offered benefits to women, and women have taken advantage of these benefits, not realizing the price they would pay in personal autonomy. Initial introduction to the welfare system opens the door to increased scrutiny and intervention into women's so-called private lives.

**Contemporary Social Services**

The first social welfare legislation in North America came out of a maternalist feminist ideology. "Second-wave" feminism arose out of the civil rights movement in Canada and other liberal democracies in the 1960s (Chunn, 1995). Second-wave feminists hoped to achieve equality in the private and public spheres, and a restructuring of the Canadian welfare state. Today social welfare legislation arises out of more "politically conservative anti-drug ideology" that emulates legal and medical interests (Kasinsky, 1994, p. 99), especially in the United States. In both periods of social welfare reform, the interests of the mother and child "have
been perceived by the state as separate, and often in conflict with each other" (Kasinsky, 1994, p. 98).

Female welfare clients are subject to "gender specific forms of social control" (Edwards, 1988; p. 221). Social workers' power lies in their ability to label women "deviant" (Amir & Biniamin, 1992), and "deserving and undeserving" (Chunn, 1995). The assessment of mothering and proper female roles is integral to welfare policy (Edwards, 1988; Maher, 1992; Maier, 1992). Although Garland (1985) fails to recognize gender differences in his discussion of welfare regulation, he does note the distinction between "the bourgeois family, which may freely conform to norms made in its image and for its benefit, and a lower-class family, which is subjected to supervision and intervention in the name of a normative order that is not its own" (Garland, 1985, p. 253).

Currently, women who receive welfare are often portrayed as an underclass of uneducated, single parents who are out of control, unfit, sexually promiscuous, cunning, who have children to continue to receive welfare benefits, and who regularly cheat the welfare system (Gorlick, 1995; Martin, 1991). These misapplied characteristics dominate conservative discourse concerning women and welfare benefits.

In contrast, Gorlick's (1995) study of single parents emphasizes the diversity of women on welfare assistance in Canada. Seeing women as unfit, helpless and overwhelmed deflects attention away from the "feminization of poverty," an
increase in families headed by women which may be attributed to their role of providing most of the support for their children, and their disadvantage in the labour market (Pearce, 1990, p. 257).

Assistance that barely (or rarely) covers the basic necessities, and the stigma of welfare, make assistance less than appealing for most women. But most important, receiving assistance opens the door to surveillance by social service agencies. Women are judged according to their fitness to care for their families and their adherence to feminine virtue.

However, the agent of social control of women is not so easily identified (Chunn & Gavigan, 1988). Women have also been agents of social control, both as social workers (Amir & Biniamin, 1992) and as health professionals (Petchesky, 1983). The fact that women are "women" is of interest to Pitch (1985); she contends that it is this position that "makes them crucial in the production and management of social control" (p. 113) in Western societies, for women are the main recipients of welfare services, and welfare service is mainly female work. Only recently have feminists acknowledged female workers' stake in the perpetuation of specific institutions of social control.

Foster caretakers receive up to three times as much financial assistance from the B.C. Ministry of Social Services for each child they care for as mothers on financial aid receive. They are also offered additional services, such as
counselling for the children and respite care. Mothers are rarely offered such services. Traditionally, mothers are refused additional support by the Ministry, whether in terms of a homemaker, daycare (unless they are attending school full time) or counselling, unless there is an open file and a social worker has been assigned to the case (Report of the Aboriginal Committee, 1992, p. 46). Having an open file and social worker, rather than just a financial worker, means that the woman is subjected to a "child protection" concern by the social worker (The People's Law School, 1993). In short, mothers are not offered assistance until their families are in a state of crisis, and preventive support is rarely offered prior to family breakdown.

In Canada, when social workers think that a child is unsafe or neglected, they can have the child removed, which is called child apprehension (Ministry of Social Services, 1996). Social workers do not need proof that a child is "in need of protection"; they can act on their own assumptions (Report of the Aboriginal Committee, 1992, p. 67). The rights of the child and the power of the Ministry supercede the rights of the parents (The People's Law School, 1993). Canadian society includes many different cultures with many different ideas about the best way to care for children. But social workers have little or no training in cultural awareness. When they are sent out to observe behaviour and to assess a situation in a home, they bring all their ethnocentric cultural baggage.
with them (Almonte, 1994). This is not to say that children are not in need of protection -- they are. It has been demonstrated that some families are unable to care for their children and seek assistance from the Ministry (Ministry of Social Services, 1992/1993, p. 22). As well, incidents of child abuse have been reported and substantiated (Ministry of Social Services, 1992/1993, p. 21).

Traditionally, social workers have been white, middle-class women, though there are male social workers too, especially in administrative positions. Making decisions about people's families, especially across cultures, can be fraught with difficulties. The social worker may not be aware of what certain behaviours mean in that culture (Almonte, 1994). An action that the parents perceive as part of fulfilling their parental roles may be interpreted as abuse.

**Child Apprehension**

Child apprehension, whether temporary or permanent, is one tool that the welfare system wields when a mother is deemed unfit or undeserving. In Canada, child welfare laws define and legislate what is considered "good parenting" (Pulkingham, 1994, p. 92). Social workers and the courts, through child welfare law, "intrude into the so-called 'private sphere' of many families" (Pulkingham, 1994, p. 92). And it is poor women and women of colour, and especially First Nations women, who are most likely to be scrutinized and to
have their children apprehended by the Ministry of Social Services and sent to foster care.

An emerging body of critical research sceptical of the foster care system has developed (see Gupta, 1995; Hawley & Disney, 1992; Humphries et al., 1992; Maher, 1992; Noble, 1991; Report of the Aboriginal Committee, 1992; Chavkin, Allen, & Oberman, 1991; Monture, 1989). These authors highlight the surveillance and intervention of social services in the lives of poor women and women of colour in Western societies.

**First Nations Children**

that "many younger Native women in Canada's jails and prisons have been raised in foster or adoptive homes which, in effect, have been an extension of the residential school policies" (p. 198).

The Report of the Aboriginal Committee (1992) states that children were apprehended because native culture did not fit white, middle-class values and norms. The lack of running water was sufficient reason to apprehend a child. It was interpreted as being in the "best interests of the child" to take native children away from their families and communities and place them in non-aboriginal families, where dominant cultural values could be learned. This not only disrupted traditional native family structure, but also fostered a "new industry: the fostering of Aboriginal children" (Report of the Aboriginal Committee, 1992, p. 19). The scope of the child apprehensions that occurred within the native community is illustrated in the Report of the Aboriginal Committee (1992), which notes that in 1955 in British Columbia, only 1 percent of children in care were native, whereas by 1960, 40 percent were native (p. 20).

Fetal Rights and Social Services

In Canada, the social service industry has extended its interest from live children to the developing fetus. Several legal case studies emphasize the growing concern about fetal rights among the medical and social service professions. In both Re Children's Aid Society for the District of Kenora and
J.L. (1981) and Re Children's Aid Society of City of Belleville and T (1987), the courts concluded that the unborn fetuses apprehended were "children" in need of protection. In Re "Baby R" (1988) a pregnant woman's fetus was apprehended. The mother was pressured into giving consent to a Caesarean moments before the surgery was to begin. What is relevant is that the child that was apprehended was not yet born. These were precedent-setting cases in Canada at the time, for the term "child" under the Family and Child Service Act was open to debate and redefinition. However, under appeal, the court upheld that "child" referred to children that have been delivered in the Re "Baby R" (1988) case. The fetus can therefore not become a ward of the court. The above apprehensions occurred when mothers failed to comply with medical advice or when social services believed the mother to be unfit to care for the unborn child. Feminists have noted emerging Canadian and U.S child welfare legislation which attempts to define the fetus as a "child in need of protection" (Chavkin, 1992; Fitzgerald, 1993; Maher, 1992; Maier, 1992). These attempts are precedent-setting in their implications for all women, and especially women who use illegal drugs.

The Medicalization of Maternal Drug Use

The interrelationship between the medical and legal professions both informs welfare policy and extends its jurisdiction (Gómez, 1994). The power that social service
agencies have over women and children is explored by Maher (1992) in relation to women who are suspected of using drugs. Maher (1992) examines how welfare policy enforces dominant norms of womanhood and mothering. She contends that the punishment of women in the U.S. who use illegal drugs during pregnancy, through arrests and child apprehensions, deflects "attention away from the fissures of gender, race and class that render these women's lives as publicly problematic" (Maher, 1992, p. 152). She cites urine sampling, treatment centres, apprehensions, fostering, reduced welfare payment, hospital experience and racial and class discrimination are discussed, as examples of controls employed outside of the legal justice system (Maher, 1992). She concludes that theories of state intervention and legal discourse fail to recognize the way women are controlled through administrative and welfare policy.

Canadian women who use illicit drugs, especially during pregnancy, are also subject to social control. In contrast to the U.S., there is no specific social welfare legislation that equates maternal drug use with neglect, or child abuse (Ministry of Social Services, 1996). However, in practice children have been apprehended by the Ministry due to their mother's illicit drug use (Sunny Hill Hospital Tertiary Task Force, 1993). There is no understanding of the complexity of family and extended family, especially for First Nations women (Report of the Aboriginal Committee, 1992).
It is well documented that women who use drugs do not seek medical services while pregnant due to their fear of social service intervention and child apprehension (Siney, 1994, 1995; Klee & Lewis, 1994; Hepburn, 1993b). A woman who uses illicit drugs is "held in contempt by her family, Child Protective Services staff, health professionals and society at large" (Tittle & St. Claire, 1989, p. 18). Of the women interviewed in their three-year study of narcotic users in British Columbia, Stevenson et al. (1956) noted that most had children in the care of relatives or social agencies.

In a Vancouver study conducted at Vancouver Children's Hospital between 1952 and 1973, social services were contacted for follow-up information pertaining to 149 children born to 101 women who had used heroin during their pregnancies. Mothers were on welfare during 122 of the deliveries. Over 25 percent of the women were First Nations women, though natives represented only about 5 percent of the provincial population at that time (Fricker & Segal, 1978, p. 360). Information was included about an additional 140 children born to the 101 mothers in the study, resulting in a total of 289 children. Only 25 percent of these children were still living with their mothers; 15.2 percent were living with relatives and 49.4 were adopted or in foster care (Fricker & Segal, 1978, p. 363).

Foster Care and NAS

The fostering of infants who may have been exposed prenatally to illicit drugs is big business in Canada and the
The foster care system is overwhelmed in urban centers. Since 1985, children who have been apprehended in the U.S. are literally warehoused and given substandard care. In New York City, infants have been kept in hospital wards for months and placed in temporary shelters (Rempel, 1989), such as old school buildings.

In Canada, infants are apprehended after birth if there is suspected maternal drug use, including alcohol use. Although Canada has not progressed to warehousing infants, the foster care system is integral to the lives of Canadian mothers whose children have been labelled with Neonatal Abstinence Syndrome (NAS). Until 1992, medical and welfare services in Vancouver did not offer support groups for mothers whose children were labelled with NAS or FAS (Fetal Alcohol Syndrome). However, Sunny Hill Children's Hospital offered a support group for foster parents who cared for children labelled with NAS. Journal articles have devoted space to the trials of the foster parents and those of medical and social service professionals, with little regard for the biological mothers of these infants.

Like other journal articles describing NAS, most articles pertaining to fostering begin with several paragraphs describing the horrors these infants experience after birth. In one of the milder accounts the reader is asked to:

Imagine a tiny baby whose high-pitched, intense screaming, induced by withdrawal from whatever variety of legal and illegal substances his mother used during pregnancy, goes on hour after hour.
Imagine yourself, sitting in a darkened room, trying to feed this underweight newborn, who cannot coordinate sucking, swallowing, and breathing and who therefore gags and chokes after every few sips of fluid. The baby cannot tolerate the stimulus overload of having your arms hold him as he tries desperately to eat. He screams in frustration and fury. Every bit of what he swallowed ends up in your lap (White, 1992, p. 13).

Evidence negates this kind of description by foster care parents and medical professionals who work with children labelled with NAS (see Frank & Zuckerman, 1993; Hepburn, 1993a, 1993b; Latchem, 1994; Morrison & Siney, in press; Myers, Olson, & Kaltenbach, 1992; Siney, 1994, 1995; Siney, Kidd, Waldinshaw, Morrison, & Manasse, 1995). These subjective characteristics may fit any infant. As further detailed in Chapter four, treatment regimens for infants labelled with NAS vary. A review of the literature on maternal drug use makes it exceedingly clear that much of the "care" provided for these infants in North America is experimental.

The apprehension of infants born to mothers suspected of maternal drug use is prevalent in both Canada, and the U.S. (Streissguth et al., 1994). The medical diagnosis of Neonatal Abstinence Syndrome (NAS) often has a "cascade effect," wherein the family is subject to Ministry intervention and eventual apprehension of infants. Family Court decisions concerning custody of infants also influence criminal court decisions. The following section will explore the impact of familial ideology on criminal and Family Court decisions on women, especially women who use illicit drugs.
VIII. FAMILIAL IDEOLOGY AND THE COURTS

As noted earlier, since the Industrial Revolution the family has been perceived as a private institution - a place where state intervention was unwanted. The family was cast as "private" and social relations within the family were not subject to public scrutiny until recently. Feminists question the illusion of the family as a private domain, stating that it has always been an unacknowledged public domain regulated by the state's non-interventionist stance and by male control and violence (MacKinnon, 1983; Rose, 1987). In addition, the right to privacy is assigned only to those families that reproduce the nuclear family form.

Feminist researchers have also begun to analyze the interplay of "gender, sexual, and familial ideology, and social control" in courtroom decisions (Daly & Chesney-Lind, 1988, p. 525). Many feminists agree that the law is mediated by ideologies, or assumptions, about social reality; Chunn and Gavigan (1991) refer to this perspective as the "law-as-ideology thesis." They contend that familial ideology recognizes only white, middle-class, nuclear families as the norm. The superiority of the nuclear family form organized around a marriage relationship, the sexual division of labour and the private/public split dominates Canadian law and social policy in regulating the private sphere (Gavigan, 1993). Familial ideology privileges the nuclear family form in both Canadian law and social policy within the "private sphere"
(Gavigan 1988), and also transmits gender and class inequalities (Barrett and McIntosh, 1990).

Early research by Carlen (1976, 1983), Daly (1987) and Eaton (1983, 1985) emphasizes the impact of familial ideology on criminal and family court decisions. Carlen (1983) also pointed out how initial prison sentencing has immediate, devastating effects on women, as well as "snowballing" effects. For example, when children are put in care as a consequence of their mother's sentencing, their placement in care is often perceived as significant evidence in determining future sentencing (Carlen, 1983). Furthermore, women sentenced to prison who had previously placed their children in care due to battering husbands were not supported for these actions. Rather, their actions to protect their children were perceived by the courts as showing them to have failed as mothers (Carlen, 1983).

Gavigan (1988) claims that the dominant family form is basically "defined and created by law" (p. 289), and Masson's (1992) study of courtroom decisions in the Lower Mainland of British Columbia demonstrates that familial ideology is reflected in the sentencing of women in Canada. Masson (1992) interviewed nine Vancouver judges and examined 110 presentence reports of women convicted of offences in Greater Vancouver, written between 1980 and 1991. On examination of the presentence reports, Masson (1992) discovered that two of the most important variables affecting sentencing decisions were
whether the defendants' children were in someone else's care, and defendants' marital status (pp. iii, iv). Furthermore, the interviews with the judges demonstrated that they held ideas about proper female behaviour which were consistent with a patriarchal nuclear family arrangement (Masson, 1992).

Clearly, lesbians and gay men have been perceived as menacing "the family" in Canada. This homophobic and heterosexist ideology is entrenched in Canadian politics, law, education and welfare systems (O'Brien & Weir, 1995). Herman (1991) states that conservative and liberal ideologies fail to problematize heterocentrism (viewing the family as naturally heterosexual), oppositional ideologies, masculinity and patriarchal relations. The legal process - the law's search for a fixed "truth" - excludes alternative discourses and oppositional ideologies, leaving little room for a radical politics of sexuality (Herman, 1991).

The dominance of the nuclear family form within legal and social policy renders all other family arrangements deviant in the eyes of the family court and the criminal justice system. Women, and especially working-class women with children, are finding that their perceptions are appropriated and diffused in the family court system (Morton, 1988). Assumptions about social reality often contain stereotypical ideals of feminism and family and of the roles of both men and women in society (Gavigan, 1993; Chunn & Gavigan, 1991; Daly, 1989; MacKinnon, 1987; Edwards, 1981). These assumptions cr
ideologies are internalized by both lawmakers and enforcers, influencing and contributing "indirectly to the reproduction of class, gender, and racial/ethnic inequalities" (Chunn & Gavigan, 1991, p. 302). Familial ideology explains disparities in sentencing for similar offences; female offenders who have "normal families" and assume appropriate gender roles often receive more lenient sentencing (Daly, 1989; Eaton, 1986; Masson, 1992; Simpson, 1989). Similar disparities can be witnessed in the medical (Gallagher, 1987) and social service professions (Chunn, 1995; Maher, 1992; Maier, 1992). Thus, sentencing decisions are often "family based rather than individual based" (Daly, 1989, p. 11). Furthermore, women who do not fit the familial model of "good" wife or mother are less protected by police and judges (Carlen, 1983; Edwards, 1987; Radford, 1987). Women who use illicit drugs are especially vulnerable to negative perceptions of their families by the legal, medical and social service professions, leading to discrimination and further "justification" for intervention.

IX. THE GENDERED NATURE OF DRUG USE

Criminalized Women

In Canada, criminalized women tend to be single, though many have dependent children (Chunn & Gavigan, 1991). They are poor and young, and often have histories of drug and alcohol abuse (Simpson, 1989). In 1991, women constituted about 15 percent of all adults charged under federal drug legislation.
(Single et al., 1994, p. 260). For pharmaceutical drug offences, women accounted for nearly one-third of convictions, though only 10 percent of all cocaine charges (Health and Welfare Canada, 1991, p. x). However, 71 percent of federally sentenced women had "drugs or alcohol [as] a factor in their offending" (Shaw, et al., 1990, p. 26).

First Nations people, comprising less than 4 percent of the total population, are overrepresented in the Canadian criminal justice system (Faith, 1993; LaPrairie, 1987); 25 percent of federally sentenced women in Canada are native Canadians (Faith, 1993; Shaw et al., 1990; Chunn & Gavigan, 1991, p. 304). In 1983, 31 percent of women at the Federal Kingston Prison for Women (P4W) were native (LaPrairie, 1987, p. 103). Masson (1992) discovered that First Nations women were more often sentenced to custodial care (41.2 percent) than were white women (25.7 percent). In addition, Faith (1993) notes that "increasing numbers of women of African heritage, from the U.S. and the Caribbean, are serving time" (p. 184) at P4W for importing and trafficking convictions. Faith (1993a) notes that most women who are sent to prison are not "career" criminals and are traumatized by their initial experience of being labelled a "criminal" (pp. 174-175).

Prostitution

Women who use illicit drugs have participated in drug-related offences such as prostitution to subsidise their incomes (see Erickson & Watson, 1990; Goldstein, 1979;
Rosenbaum, 1981; Taylor, 1993). Smart (1985) claims that the law has always successfully divided women. Women who do not fit into the familial model of good wife or mother receive less protection from police and judges (Edwards, 1987; Radford, 1987) and from society in general. Women are viewed as either good or bad, chaste or unchaste. The law has usually been concerned with controlling prostitutes, not prostitution (Lowman, 1988; Smart, 1985).

In Canada, new prostitution legislation was enacted in 1985 and the offence of "communicating in a public place for the purpose of prostitution" was created. There are now three types of crimes related to prostitution in Canada: procuring and living on the avails of prostitution; bawdy-house offences; and communication for the purpose of prostitution. Although prostitution in itself is technically legal, to communicate for the purpose of buying or selling sexual services in public is illegal, and any place used for the purpose of prostitution many be defined as a bawdy house. Therefore it is very difficult for women and men to practise prostitution in Canada, and the current laws related to prostitution ensure that prostitutes remain marginal and censured (Lowman, 1991).

Lowman (1988) notes that women have historically had few resources to sell "other than their sexuality" (p. 54). Therefore, prostitution cannot be understood outside of economic and gender relations in society. However, not all
prostitutes are abused, poor and unskilled (Shaver, 1993). Attempting to understand prostitution outside of male demand for it is also problematic. Female prostitutes are arrested more often than their customers (Shaver, 1993). Prostitution is not a female crime, or a sign of female promiscuity; rather, it is primarily an economic choice for both women and men.

The relationship between prostitution and illicit drug use varies depending on the level of prostitution engaged in. As early as 1979 Goldstein noted that prostitution was most likely to precede "addiction" in high-class prostitutes. Low-income prostitutes were more likely to be "addicted" to illicit drugs prior to engaging in prostitution (Goldstein, 1979, p. 145). There is no direct link between prostitution and addiction (Erickson & Watson, 1990; Goldstein, 1979). Erickson and Watson (1990) note that "female addicts engage in less prostitution...than is commonly believed" (p. 268). Few women who use illicit drugs engage exclusively in prostitution; rather, they may engage in a wide range of criminal activities (Erickson & Watson, 1990). For low-income women, prostitution is solely a source of income. Poverty and lack of education, skills and employment lead many women to work as prostitutes (Johnson & Rodgers, 1993; Shaver, 1993).

Research on female drug users

Although women who use illicit drugs are subject to arrest due to drug-related offences, and because the
possession of narcotics is a criminal offence in Canada and many other Western nations, there was little research about women who used illicit drugs until the 1970s. The majority of studies (except for Blackwell 1983; Erickson et al., 1987; Waldorf, et al. 1991) focused on men's perceptions of illicit drug use (Addiction Research Foundation, 1994; Reed, 1987). Until recently, there was little feminist response to critical research on illicit drug use. Early literature on female drug users centred on legal use of medically prescribed drugs and on multinational pharmaceutical companies (Cooperstock & Hill, 1982; Lexchin, 1984; McDonnell, 1986; Penfold & Walker, 1983). Women are prescribed more pharmaceutical drugs than are men (Ettorre, 1992; Harding, 1986; Lexchin, 1984; McDonnell, 1986; Penfold & Walker, 1983), and most of these drugs are related to their reproductive capacity (McDonnell, 1986, p. 4). Women also consume more legal psychoactive drugs than men (Addiction Research Foundation, 1994). Like Cooperstock and Hill (1982), Lexchin (1984) noted that women were prescribed pharmaceuticals to cope with problems which stem from their subordinate role in society. Lexchin (1984) claims that drugs are prescribed by doctors to tranquilize women who are not complacent in traditional familial roles, when what is really needed is social change.

The fact that there is little ethnographic1 information

1The term "ethnography" refers to the methodological approach developed by sociologists and anthropologists. Ethnographic sociological studies on illicit drug use seek to
about female illicit drug users is well-documented (Addiction Research Foundation, 1994; Ettorre, 1992; Inciardi, Lockwood, & Pottieger, 1993; Rosenbaum, 1981; Taylor, 1993;). Historically, most research on illicit drugs has concentrated on male users (Addiction Research Foundation, 1994). The focus has been on "the man about town," rather than the mother at home with kids (see Biernacki, 1986; Hanson, 1985; Preble and Casey, 1969; Waldorf & Biernacki, 1979; Winick, 1962).

The current attention to crack cocaine in the United States has also generated several studies, including Inciardi, Lockwood, & Pottieger's (1993) research on women and crack cocaine. Their research consisted of paid interviews with women drawn from the street and from treatment centres. However, their short interview sessions and recruiting of participants within the first 48 hours after entry into drug treatment centres bring up ethical dilemmas and wider methodological questions. Individuals entering treatment are usually quite vulnerable (they may be frightened and emotionally fragile, as well as experiencing physical withdrawal symptoms), and may feel that they must participate study the illicit drug user "from within their culture rather than from outside it and to present their world as they see it" (Waldorf et al., 1991, p. 14). The concept of "career" employed by ethnographic sociological studies "makes it possible to look processually, sequentially, temporally, social psychologically, and (as much as possible), nonjudgmentally at the individual's experience with drugs (or any other type of career)" (Rosenbaum, 1981, p. 9). Traditionally, ethnographic sociological studies are based on participant observation and in-depth interviews.
in an interview in order to be seen by staff as compliant. Furthermore, treatment centres represent a captured population. It is usually the most visible and problematic drug users - a small percentage of all drug users - who enter treatment.

Only three ethnographic sociological studies of women who use illicit narcotics exist: Marsha Rosenbaum's (1981) study of female heroin users in San Francisco, California; Avril Taylor's (1993) study of female injectors in Glasgow, Scotland; and Lisa Maher's (1995) study of women in low-income minority neighbourhoods in New York City. Rosenbaum's (1981) and Taylor's (1993) studies are based on the sociological concept of "career," which was introduced by the Chicago School. Rosenbaum's focus is a career of narrowing options, and Taylor's is the strength and rational decision-making qualities of female drug users. In-depth interviews were conducted by both researchers, in addition to a 15-month period of participant observation by Taylor (1993). Taylor (1993) argues that Rosenbaum's (1981) study was flawed, due to the fact that participants were paid, and there was no participant observation. Nevertheless, both focus on the user's perspective and contribute to a fuller understanding of the lives of women who use illicit drugs.

**Feminism and Drug Treatment**

Women who use drugs have traditionally been perceived as more out of control (Inciardi et al., 1993), deviant (Reed,
1987) and pathological than their male counterparts (Cuskey, 1982; Ettorre, 1992; Perry, 1979), even though men use more illicit drugs than women do (Addiction Research Foundation, 1994). Current and past research views women as more sexually promiscuous (see Inciardi, Lockwood, & Pottieger, 1993; Reed, 1987; Stevenson, et al., 1956), more passive (Perry, 1979) and morally weaker than men (Mondanaro, 1989). In addition, women who use drugs have been viewed as victims, both of drugs and of men who have led them astray (Maher, 1995). Traditional theory regarding women and drug use perceived women as passive and lacking agency (Henderson, 1993a; Maher, 1995). In relation to cocaine use, Erickson and Murray (1989) note:

After reviewing the scientific literature...there is no evidence that women's cocaine use exceeds that of men's, that women's rates of use are growing faster than men's, or that female cocaine users experience more problems than male cocaine users. Since the deviant image of the female cocaine user is a social construction lacking a factual basis, we conclude that a different standard is being applied to women who use cocaine than to men who use cocaine (p. 135).

Much of the early feminist literature examined individual pathology models of addiction, in which addiction was considered a disease. Until recently, the majority of research on illicit drug use was developed using male samples which then generalized conclusions to female users (Addiction Research Foundation, 1993; Reed, 1987). However, critical interpretations (Biernacki, 1986; Peele, 1985, 1989; Peele & Brodsky, 1991; Waldorf, Reinarman & Murphy, 1991) and harm reduction (see O'Hare et al., 1992) and feminist analyses of
drug treatment for women (Ashbrook & Solley, 1979; Blume, 1992; Bepko, 1991; Ettorre, 1992; Kasl, 1992) have expanded to include gender differences and alternative views of drug use. A number of feminists have offered alternative views related to drug treatment and women (Ashbrook & Solley, 1979; Bepko, 1991; Blume, 1992; Dowsling & MacLennan, 1978; Ettorre, 1992; Kasl, 1992; MacKinnon, 1991; Penfold & Walker, 1983; Reed, 1987). Originally, feminists concentrated on the lack of drug treatment services that incorporated the concerns of women surrounding childcare, family responsibility, gender inequality and treatment needs. Later research noted a link between addictive drug use and physical and sexual abuse (Barrett & Trepper, 1991; MacKinnon, 1991; Mondanaro, 1989). Although many feminist frameworks have abandoned the disease model of addiction (Ettorre, 1992), others incorporate the disease model and extend and modify the "12 steps" of Alcoholics Anonymous (A.A.) to reflect the concerns of women (Bepko, 1991; Kasl, 1992). Foremost, feminists argue that the 12 steps fail to address historical gender inequalities and the socioeconomic structure of society that contributes to these inequalities.

Both Henderson (1993a) and Maher (1995) note how drug treatment and theory have integrated the belief that female drug users have little agency. In addition, feminists have explained female drug use as a coping mechanism to deal with stress and/or psychological problems. However, there has been
little attention to the positive aspects of drug use. Henderson (1993a) notes how feminists have failed to address the positive aspects of women's drug use, especially among young women. Henderson (1993a) and Maher (1995) emphasize the wide range of drug experiences, and the fact that not all women drug users are abused, downtrodden or dominated by men. Rather, many women choose to use drugs, both licit and illicit, because they are fun, positive and empowering.

Outside of Ettorre (1992), feminist literature related to drug treatment rarely critiques the criminalization of drugs and rarely offers suggestions regarding decriminalization and legalization of drugs. Feminist frameworks critique patriarchy, gendered social equality, familial responsibility, physical and sexual abuse and victimization and survival.

Feminist researchers have often failed to examine the race, class and gender conflicts inherent in current drug policy. Women are offered alternatives to A.A. programs which more fully address their needs, and explore their gendered role in society. However, the full ramifications of drug legislation are not incorporated into drug treatment programs. Furthermore, few drug treatment services in North America have been able to adopt alternatives to the A.A. abstinence doctrine, for alcohol and drugs funding agencies refuse to recognize alternative treatment programs that are not abstinence based, and consequently deny funding.
Maternal Drug Use

Women who use illicit drugs have recently been subject to legal, welfare and medical regulation. Medical regulation of illicit drug users focusing on maternal heroin use emerged in the 1960s. Regulation focusing on cocaine use emerged in the 1980s. Social welfare professionals began to view maternal drug use as a social problem in the mid-1980s. In the U.S., legal sanctions against maternal drug use have been initiated by 27 states since the mid-1980s (Paltrow, 1992). Also in the U.S., from 1985 to 1992 there have been an estimated 167 women arrested on criminal charges stemming from their behaviour during pregnancy; most of the prosecutions are due to "allegations" of illicit drug use during pregnancy (Paltrow, 1992). In all of these cases, prosecutors have used legal statutes intended for other purposes and extended them to encompass pregnant women (Paltrow, 1992). Many of these cases involve doctors who contacted legal authorities about the mothers' suspected illicit drug use (Stephenson & Wagner, 1993).

Mothers have been arrested for child abuse and neglect, child endangerment, drug possession, assault with a deadly weapon, manslaughter, homicide and trafficking to the fetus in utero. All these charges pertain to allegations of taking drugs while pregnant. This raises the question of whether a "fetus" is protected by law prior to birth. In the cases where
race was identified, 70 percent of the women charged were women of colour (Paltrow, 1992).

Legal attention focuses on lifestyle and assumed increase in female use of illicit drugs. Bloom et al. (1994) describe the increase in the number of drug-using women imprisoned in the U.S., where one out of three women are serving time for drug offences (an increase from one in ten in 1979). Over a third of these women are serving time for "possession" (Bloom et al., 1994, p. 1).

Women who use illicit drugs often lose custody of their infants at birth or later, due to social service intervention. In Canada, mothers who use illicit drugs are perceived as placing their children at risk. Feminists have introduced the term "the criminalization of pregnancy" to describe legal sanctions against pregnant women in Western society. Discourse centres on suspected maternal harm to the fetus and conjectured prenatal harm as child abuse. In North America, laws pertaining to "legal persons" have been applied to the fetus, and mothers have been arrested, incarcerated and subjected to medical and surgical interventions in order to prevent "fetal harm" (Kolder, Gallagher, and Parsons, 1987). In Canada, First Nations women, poor women and single mothers appear to be overrepresented in terms of arrests, child apprehensions and medical interventions (Chunn & Gavigan, 1991; LaPrairie, 1987; McLaren, 1990; Monture; 1989).
Although illicit drug use is viewed as not consistent with good mothering, many researchers have demonstrated that women who use illicit drugs can be adequate parents (Hepburn, 1993a; Leeders, 1992; Taylor, 1993). Leeder’s (1992) two year longitudinal study in the Netherlands of 35 parents and their children who were "hard" drug users, and 31 matched control foster families, demonstrates that a high percentage of the "drug" families were doing well. In addition, in the drug family sample, "there were no significant correlations found between type or quantity of drug use, on the one hand, and various measures of parent-child interaction quality, on the other" (Leeders, 1992, p. 207).

Like feminist research on drug treatment, most feminist research concerning maternal drug use has failed to examine the social construction of "good" and "bad" drugs, the consequent negative effects of the Narcotic Control Act and the social construction of Neonatal Abstinence Syndrome (NAS). Most feminist and nonfeminist research on maternal drug use overlooks how punitive legal, medical and social service policy stems from the criminalization of specific drugs as well as from social attitudes regarding women, reproduction and mothering. There has been little critique by either feminists or nonfeminists concerning the authenticity of NAS as a medical diagnosis and the consequent medical care of infants labelled with NAS. However, assumptions regarding the
harm of illicit drugs to fetal health inform medical, social service and legal policy.

Critical drug research successfully reveals the social fictions surrounding illicit drug use. The same concepts can be applied to maternal drug use. In this thesis I have constructed a framework for the following literature review through the integration of critical research on illicit drug use with feminist analyses of gender, maternal drugs, reproductive autonomy and mothering.
CHAPTER 4 - Literature Review: Maternal Drug Use

I. INTRODUCTION

In examining the literature on prenatal exposure to drugs it becomes apparent that the scientific community and legal and social service professionals have a growing interest in the developing fetus and neonatal outcomes. Rarely is this interest or concern extended to the mother. And when it is, increased social control, regulation and monitoring are suggested. This chapter is focused on drug screening to identify maternal drug use, race and class bias in drug screening, prenatal exposure to narcotics; and prenatal exposure to cocaine. Methodological flaws in the research are also examined. The chapter concludes with a discussion of perceptions of "risk" and the cultural construction of Neonatal Abstinence Syndrome (NAS).

Legal and social service restrictions on women who use illicit drugs during pregnancy have emerged due to concern for the infant and the "double risk" infants are exposed to due to the physiological sequelae of addiction and abuse by parents. The actual negative effects of maternal drug use must be examined. This chapter postulates that the "risk" of physiological sequelae of addiction is demonstrated to be less than previously thought and that most parents are capable of caring for their children. If this is the case, we must examine the social construction of NAS and of risk and ask why
mothers who use illicit drugs are punished through legal, medical and social service interventions.

Antenatal and Infant Care: \textit{WAS}

The environment of the fetus during pregnancy is unique. During pregnancy the fetus obtains all of its essential nutrients and eliminates waste through the placenta. Thus the fetus does not have to rely on its own organs, many of which are not fully developed during gestation. Rather, oxygen and nutrients travel from the mother's blood to the fetus, and waste travels from the fetus to the mother's blood. One concern surrounding maternal drug use is the closed environment of the fetus. The fetus cannot excrete drugs, so drug levels may build up (Institute for the Study of Drug Dependence (ISDD, 1992). As well, at different stages of gestation the fetus may be more vulnerable to maternal drug use and to other toxic substances to which the mother may be exposed. Both licit and illicit drugs pass through the placenta to the fetus. During the first trimester toxic substances introduced to the fetus may cause teratogenesis or structural abnormalities. For example, Thalidomide, a tranquilizer, was given to pregnant women during the first trimester in the 1960s to alleviate nausea and morning sickness. It was later discovered that Thalidomide produced abnormal limb growth in fetuses.

Many maternal drug use studies look at short- or long-term symptoms in infants exposed prenatally to drugs but fail
to specify which drugs were used and whether they were licit or illicit. One reason for the lack of specificity may be the prevalence of polydrug use and the wide array of drugs that have become available through the rise of the pharmaceutical industry. However, this failure to specify whether it is alcohol, cocaine, cigarettes or heroin that the fetus has been exposed to leads to generalizations that may not be accurate. Most research on prenatal drug use fails to isolate other variables that affect pregnancy.

Furthermore, the discussion of prenatal exposure to drugs rarely includes the needs or concerns of the mothers involved. Fetal rights and fetal harm are the foci, and mothers are often absent from the discussion (see Chasnoff, 1988b; Committee on Drugs, 1983; Committee on Substance Abuse, 1990; Deren, Frank, Schmideidler, 1990; Hadeed & Siegel, 1989; Kaltenbach & Finne& 1989; Lauridsen-Hoegh, 1991). When mothers are discussed, increased regulation and monitoring is usually proposed, for it is not always obvious who uses drugs during pregnancy. For this reason, drug screening, in the form of urine toxicology tests, has been adopted by some doctors and maternity hospitals in North America.

II. DENIAL AND DRUG SCREENING

Since the 1950s, it has been evident that the medical profession is sceptical of information obtained from illicit drug users in relation to the quality and quantity of their drug use. Women were especially suspect when pregnant, and
since the early 1960s doctors have discussed the denial and manipulation displayed by pregnant women who used illicit drugs. The medical profession's historical surveillance and control of "immoral and deviant" women, especially during pregnancy, has been extended to illicit drug users. One doctor revealed how a female patient had hidden drugs in a plastic bag placed in her vagina. He advised that "these girls be repeatedly re-evaluated pelvically during a hospital stay, even if the initial gynaecologic examination reveals no abnormal findings" (Hofmeister, 1971, p. 723). It appears that doctors are often more concerned with controlling female patients than with practising medicine.

Stone et al. (1971) notes that it is impossible to obtain data on the total length of labour for women who use illicit drugs because of "their unreliability as historians" and their need to delay their arrival at the hospital "in order to satisfy their need for a last 'fix' before submitting to 'authority'" (Stone et al., 1971, p. 718). Although Stone et al. (1971) found that the women in their study had a low incidence of maternal obstetric complications, they were quick to identify these women as "addicts" (p. 722). The male-dominated medical profession views all women as incapable historians of their own birth process (Oakley, 1986). Women suspected of using illicit drugs are viewed as particularly unreliable in relating their own experiences of their birth process and their drug use.
It has been advanced by doctors that women deny maternal drug use, and writers claim that as many as 20 to 25 percent of women deny their drug use (Williams & Bruce, 1994, p. 1470). In the past, women were identified by medical professionals as illicit drug users through observation, checking for needle puncture marks, lack of prenatal care and single mother status (Stone et al., 1971). In British Columbia, Chief Coroner Cain, expressed concern that early discharge from maternity hospitals compounded the failure to identify infants exposed prenatally to drugs (Cain, 1994). Observation and intake history are still used today in identifying maternal drug use, but they are now accompanied by identification through the administration of urine toxicology tests (Chasnoff, 1988a;). Many medical professionals advocate urine screening for all women suspected of maternal drug use upon admission to hospital (Chasnoff, 1988b), and emphasize the lack of "frankness and candor" of women when surveyed about their maternal drug use (Robins & Mills, 1993, p. 13). In consequence, urine screening has often been administered without the mother's consent (Furio, 1994).

It is argued that infants need to be identified early so that protection and medical attention can be available to them (Peak & Papa, 1993; Robin-Vergeer, 1990). Ultrasound and electronic monitoring are recommended for validating the accuracy of mothers' observations of fetal activity (Robins & Mills, 1993, p. 26). White (1987) advocates drug screening and
increased surveillance of all newborns when there is a history of maternal drug use and meconium (the first intestinal discharges of the newborn) found in the amniotic fluid. As well, meconium testing and hair analysis are used in some hospitals. Many researchers discuss how promising these new techniques for assessment of prenatal drug exposure are (Albersheim, 1994; Robins & Mills, 1993), without fully addressing the ethics of subjecting mothers and infants to medical testing with or without consent.

**In utero** drug exposure is usually determined through drug testing (urine analysis) of mothers during delivery. However, these tests are unreliable and can only tell what drugs a women may have used within the last 24 to 72 hours (Humphries et al., 1992, p. 90). Drug testing cannot distinguish between first-time, occasional and dependent drug use. More important, drug testing cannot determine whether an infant is adversely affected by its mother’s drug use.

Hepburn (1993b) notes that, though abstinence from drugs may be sought during pregnancy, it is not essential, so interventions such as urine screening are unnecessary. Rather than testing, the Women’s Reproductive Health Service in Glasgow offers social and economic support through early involvement with social work agencies to promote stability. Stability of lifestyle, rather than abstinence, is seen as essential for acceptable child care (Hepburn, 1993a, p. 57). Siney (1995) has developed a coordinated maternity program in
Liverpool that strives for "normalization" for women who use illicit drugs during pregnancy. As in Glasgow, abstinence is not required and social and economic support is offered.

Often researchers have ignored the problems associated with urine screening for drugs. For example, alcohol is difficult to detect due to its quick metabolization and excretion in the urine. Alcohol is often abused by female drug users and rarely tested for, especially by private doctors and hospitals (Chasnoff 1988b). Chasnoff, Harvey, Landress, and Barrett (1990) claim that the use of alcohol is most likely underreported in their Florida study of maternal drug use.

In New York City, information on illicit drugs is listed on birth certificates. Mothers are routinely tested for drugs at the time of delivery. However, data detailing maternal use of tobacco and alcohol are not available (Kaye, Elkind, Goldberg, Tytun, 1989). Health professionals support testing and monitoring of women who test positive for illicit, rather than licit, drugs, though tobacco use is associated with low birth weight and alcohol is a known teratogen (Myers, Olson, & Kaltenbach, 1992). Besides being our most toxic drugs, alcohol and tobacco are more widely used in Canada than illicit drugs (Single et al., 1994).

Often it is unclear which drugs are being screened for, and there has been no consistency in screening for specific drugs at different hospitals. Chasnoff et al. (1990) screened
for alcohol, cannabinoids, cocaine and opiates in their study of women in Pinellas County, Florida. Although cigarettes are thought to cause the same kinds of prenatal effects as cocaine and opiates, such as low birth weight, they were not included in the study. A retrospective study of 103 opiate-dependent women and a nondrug-using control group in Liverpool identified "cigarette consumption rather than drug usage as the main factor in the birth weight difference" between the two groups (Siney, Kidd, Walkinshaw, Morrison and Manasse, 1995, p. 72).

Furthermore, maternal drug research clearly demonstrates that alcohol and tobacco use are common among mothers who do not use illicit drugs (Higgins, Moxley, Pencharz, Mikolainis, & Dubois, 1989), and mothers who are illicit drug users (Chasnoff, 1989; Chasnoff et al. 1990; Graham & Koren, 1991; Siney, 1995). Often more than 80 percent of pregnant women who use illicit drugs test positive for tobacco in research studies (Boer & Kreyenbroek, 1989; Fulroth, Phillips, Durand, 1989; Mastrogiannis, Decavalas, Verma, Tejani, 1990). In 1990, 77 percent of women (aged 15 and older) in Canada reported that they were current alcohol drinkers, and 28 percent stated that they currently smoked tobacco (Single et al., 1994). It is also documented that tobacco smokers drink more alcohol than do nonsmokers (Single et al., 1994). But studies in the past relating smoking to low birth weight failed to reveal how
tobacco use is associated with heavy alcohol use (Chasnoff, 1988a, 1988b).

Siney, Kidd, Walkinshaw, Morrison, and Manasse (1995) state that a reduction of cigarette smoking is the overall aim of their maternity services in Liverpool. Liverpool opiate users often smoke heroin rather than injecting it, and health professionals suggest that low birth weight may be more acceptable than health problems associated with injecting heroin (Siney, Kidd, Walkinshaw, Morrison, & Manasse, 1995).

Many researchers have noted that drug use is only one variable of many that may affect pregnancy. Cigarette smoking, alcohol use, caffeine intake and polydrug use should be controlled for in research studies on maternal drug use. More to the point, variables such as undernourishment, distribution of calories, past health, poverty, shelter, antenatal care and environmental factors significantly affect pregnancy outcomes and maternal health. These variables should be accounted for in studies related to maternal health and pregnancy outcomes.

Concern about illicit drug use prompted urine toxicologic screening of 29,294 women admitted for delivery at two-thirds of the maternity hospitals in California in 1992 (Vega, Kolody, Hwang, & Noble, 1993a). Data based on admission forms and urine testing of every woman in the study revealed that the primary drugs of concern for pregnant women were not illicit drugs, but licit drugs - alcohol and tobacco (Vega et al., 1993a). This should not be interpreted as evidence to
promote tactics to regulate and curtail legal drug use during pregnancy. Rather, it should be examined as further evidence discrediting the panic related to illicit drug use and pregnancy which has developed in North America.

Chasnoff et al.'s (1990) study in Pinellas County, Florida was conducted during a one-month period in the first half of 1989 in five public health clinics and 12 private obstetrical offices in the same county. Urine samples were collected from all pregnant women enrolled for prenatal care. In this study, 14.8 percent of 715 pregnant women tested positive for alcohol and other drugs (Chasnoff, et al., 1990).

Similarly, in the California study of 29,494 women delivering infants, 11.35 percent tested positive for drugs and alcohol. On examination, 6.72 percent of the mothers specifically tested positive for alcohol use. The prevalence of tobacco use (which was self-reported) was 8.82 percent, raising the total positives to 20.17 percent (Vega et al., 1993a). Prescription drugs (benzodiazepines, barbiturates and amphetamines) accounted for 1.71 percent of the total number of positives. Legal pharmaceutical drugs such as minor tranquilizers and barbiturates are rarely tested for in maternal drug studies, although women are prescribed more of these drugs than men (McDonnell, 1986). Furthermore, drug studies show that women use more legal prescription drugs and over-the-counter drugs than illicit drugs (Adrian, 1995; Single et al., 1994).
Chasnoff et al. (1990) did not include testing for tobacco and other legal drugs in their 1990 Florida study on maternal drug use, and only 1 percent of the mothers tested positive for alcohol use. As mentioned above, Chasnoff et. al. (1990) state that alcohol use was underreported in this study. Positive tests for illicit drugs account for only 3.49 percent of all drug use in the California study, and 15.6 percent in the Florida study. Positive THC/marijuana tests account for 1.88 percent of the 3.49 percent total of illicit drug use in the California study, and 11.9 percent of the 15.6 percent total in the Florida study. In sum, methamphetamines, cocaine, methadone and opiates account for only 1.61 percent of the total 20.17 percent positives in the California study. Cocaine and opiates account for 3.7 percent of the total 14.8 percent positives in the Florida study.

Rarely do social science, medical and legal articles emphasize the low percent of illicit drug use demonstrated in urine toxicology studies. Rather, the total results for all maternal drug use (licit and illicit) are advanced to support increased regulation and monitoring of pregnant women (see Chasnoff et al. 1990; Kaye et al. 1989; Peak & Papa, 1993; Robins & Mills, 1993). Consequently, the negative ideology concerning illicit drug use remains intact. As well, though some research challenges what urine toxicology screening data for illicit drugs tell us, it fails to analyze the significant use of legal drugs and the use of marijuana (our most benign
drug) in relation to other illicit drugs, though racial
difference in respect to different drug use is pointed out
(Vega, et al., 1993b). A growing number of feminist writers
have begun to examine the lack of analysis regarding licit
drugs in research models (see Blume, 1992; Gieringer, 1990;
Humphries et al. 1992; Merlo, 1993; Siney, 1995; Siney et al.,
1995; Paltrow,

Although Chasnoff (1988b) states that infants exposed
prenatally to marijuana experience abstinence symptoms, the
discussion of NAS and THC/marijuana is not conclusive. The
Institute for the Study of Drug Dependence (ISDD) (1992)
states that no significant harmful effects of THC/marijuana
have been confirmed in mother or fetus. Furthermore, Dreher,
Nugent, and Hudgins' (1994) study demonstrates that Jamaican
women who used marijuana heavily during pregnancy have
healthier babies than women who are light users or nonusers of
marijuana during pregnancy. Nugent states that the infants
exposed to heavy marijuana use prenatally:

were more autonomically stable at 30 days than the
infants of the light users and the non-users. On
the Supplementary items of the Brazelton Scale they
showed better quality of alertness, they were less
irritable, needed less examiner support, had better
self-regulation and were judged to be more
rewarding for caregivers (Nugent, 1994, p. 5).

The Jamaican women who were defined as heavy users of
marijuana were better educated and had fewer children than the
other women in the study. The researchers noted that
environmental influences, such as cultural, social and
economic characteristics of the mother, may override drug effects, and that marijuana was just one variable affecting maternal outcomes (Nugent, 1994, p. 5).

So far, there has been little controversy over the adverse effects of THC/marijuana for adults (ISDD, 1992; Julien, 1992). Although it is still illegal to possess marijuana in Canada, most research confirms that it is the most benign illicit drug in use today (Boyd, 1991; Wijngaart, 1991; Alexander, 1990).

**Extrapolation and Increased Rates of Maternal Drug Use**

A 1988 survey by Chasnoff reported that rates of prenatal exposure to drugs in a survey of 36 hospitals in the U.S. ranged from 0.4 percent to 27 percent, with an average of 11 percent (Gieringer, 1990). Chasnoff's estimates were swiftly publicized by other researchers and journalists. However, rather than citing the actual data results, the figure 11 percent was reduced to one in 10 infants exposed prenatally to drugs - resulting in the figure of 375,000 infants prenatally exposed to drugs annually in the U.S. Chasnoff's study, which was later interpreted as "375,000 crack babies born annually" by journalists and researchers, was based on positive urine toxicology of an average of 11 percent of women at the time of delivery in mostly public hospitals (which means mostly poor women covered by Medicaid or poor women without health insurance), in predominantly urban inner-city locations. The study does not distinguish between crack and cocaine use, as
urine toxicology screening cannot distinguish between the two forms of cocaine.

The figure of 375,000 crack babies born each year in the U.S. has been promoted by journalists and researchers, even though both U.S. and Canadian research notes that only one percent or less of the adult population uses cocaine on a regular basis and that overall cocaine use has been declining since the mid 1980s (Humphries, 1993; Alexander, 1990; Waldorf et al., 1991, p. 2). Furthermore, the negative effects associated with maternal cocaine use on the developing fetus are unsubstantiated (Frank & Zuckerman, 1993; Lindenberg et al., 1991; Myers et al., 1992).

Again, it is interesting to note that little attention is given to the higher prevalence of licit maternal drug use, such as alcohol and tobacco use, in the Chasnoff et al. (1989) survey. In the face of research which demonstrates that illicit drug use is not as prevalent as previously thought, that alcohol and nicotine pose the greatest prenatal risk to the infant, and that the effects on infants of prenatal use are not verifiable using current testing methods, researchers still insist on continuing and increasing urine screening of pregnant women and infants at delivery. This practice contributes to the ideology of "good" and "bad" drugs and "good" and "bad" mothers.
Race and Class Bias

Humphries et al. (1992) discuss the racial and class biases of drug testing in U.S. hospitals and the consequences of this practice. Identification of women at risk for delivering an infant prenatally exposed to drugs is accomplished through medical protocols. Failure to receive prenatal care and/or lack of health insurance appears to be the most important risk factor for initiating drug testing in the U.S. (Noble, 1991, p. 7). Medical protocol was established to justify urine screening and the gathering of information to be turned over to child protection agencies. Furthermore, "high risk" women are tested without informed consent (Noble, 1991). Noble (1991) argues that discriminating against women who use drugs is a class and race issue. This appears to be the case; black women were tested ten times as frequently as white women in a Florida study, even though women of all races and socio-economic status use drugs during pregnancy (Chasnoff et al., 1990). Black and white women had similar toxicology rates when tested for maternal drug use in the Florida study (Chasnoff et al., 1990), although Vega, Noble, Kolody, Porter, Hwang, & Bole (1993b) noted that black women's overall drug and/or alcohol rate was higher than those of Hispanic women and white non-Hispanic women in their California study. Vega et al. (1993b) point out that black women represented only 5.5 percent of their study sample; therefore, their infants who
were exposed to alcohol and drugs were a relatively small group in contrast to those of nonblack women.

In New York, where prenatal drug exposure is listed on birth certificates, many instances of drug use are still omitted, specifically in the case of white, middle- and upper-class women. Nevertheless, Robins and Mills (1994) still advocate the practice, as it may "allow for discovery of trends in use over time" (p. 10). Robins and Mills (1994) ponder the increase in maternal drug use by black women as listed on New York birth certificates. They comment that these increases may be due to: differences between New York mothers and the rest of the population; hospitals in New York that care for black women doing more testing; obstetricians in New York requesting more drug testing because black women have smaller babies; and, doctors being more concerned about black women using illicit drugs (p. 12). Robins and Mills (1994) never question whether increases in maternal drug use by black women may have to do with existing screening practices.

The preceding sections have concentrated on the variables that identify maternal drug use. The next two sections will examine the effects of maternal narcotic use, including prenatal exposure to opiate derivatives and cocaine, as well as short- and long-term problems associated with maternal drug use.

III. MATERNAL DRUG USE
Although there is controversy over whether maternal drug use causes long-term problems and which drugs may affect long-term development, one Canadian doctor and one social worker state that "most drugs of abuse carry some degree of long-term neuro-developmental problems, these infants will need to be assessed continually during infancy and the preschool years" (William & Bruce, 1994, p. 1475). Another Canadian doctor claims that "over the last twenty-five years, the behavioral, neurological [messages to the brain], and teratological consequences of drug and alcohol abuse during pregnancy have been established" (Steinberg, 1994, p. 12). The B.C. Chief Coroner's recent report claimed that drugs (though he failed to say which drugs) "can disrupt the normal development of the embryo and fetus before birth" (Cain, 1994, p. 47). Cain claims that infants prenatally exposed to cocaine have higher rates of "congenital anomalies, neurobehavioural aberrations and infant mortality (e.g., Sudden Infant Death Syndrome, or SIDS)" (Cain, 1994, p. 47).

However, the above claims are not substantiated, as the effects of maternal drug use, outside of possible withdrawal symptoms, have not been confirmed. Furthermore, different drugs have different effects on the developing fetus. For example, there seem to be more credible evidence that prenatal exposure to alcohol may contribute to Fetal Alcohol Syndrome, though several articles are critical of the scientific premise of FAS (ISDD, 1992; Plant, 1985). However, prenatal
exposure to cocaine and narcotics has not yet been empirically linked to a "syndrome."

The above section focuses on the prominence of misleading generalizations that contribute to the general confusion surrounding maternal drug use and prenatal exposure. It is difficult to acquire accurate information concerning prenatal exposure to drugs, as authors tend to make statements which have very little scientific validity (Mayes, Granger, Bornstein & Zuckerman, 1992). As we will see, it is still very unclear how, or indeed whether, illicit drugs adversely affect the developing fetus.

**Prenatal Exposure to Narcotics**

The long- and short-term affects of maternal use of narcotics (opium derivatives) are somewhat controversial. Since the advent of criminalization of narcotics in Canada and most Western countries, health problems associated with narcotics are difficult to distinguish from health problems stemming from the illicit status of the drug and from users' socio-economic environment. Judson (1973) noted that women who used heroin in the United States were malnourished, unlike women in England, where infants experiencing withdrawal symptoms from maternal heroin use were a rare occurrence. Even though North American physicians know that heroin has a shorter withdrawal period than methadone (Robins & Mills, 1993), heroin is not advocated for use during pregnancy. In
fact, it is illegal to use heroin in drug management during pregnancy (or drug treatment) in Canada and the United States.

Early medical research on maternal narcotic use noted that heroin use caused intrauterine growth retardation, microcephaly (small head circumference), stress (Naeye, Branc, Leblanc, & Khatamee, 1973) and spontaneous abortion (Rementeria & Nunag, 1973). In 1979, Finnegan (1979) reported and diagnosed Narcotic Abstinence Syndrome (NAS), establishing guidelines for care. Higher rates for sudden infant death syndrome were attributed to maternal heroin use (a five- to tenfold increase) (Chasnoff, 1988b). In addition, low birth weight and length, and withdrawal symptoms, have most often been attributed to prenatal exposure to narcotics. More recently, withdrawal (Hepburn, 1993a, 1993b), low birthweight associated with cigarette smoking and preterm delivery (Siney, 1994; Siney et al., 1995) appear to be the most serious problems associated with maternal drug use.

Prior to 1980, studies of maternal drug use concentrated on heroin and methadone use. Infants experiencing withdrawal were said to experience problems ranging from flu-like symptoms and tremors to dehydration and, possibly, death. Early medical studies cited infant withdrawal as a specific effect of maternal narcotic use and discussed the suffering infants experienced due to their mother’s illicit drug use. Stern (1966) states that all children of mothers who use heroin will be born "addicted and with withdrawal symptoms"
physicians became advocates for "prevention of unnecessary suffering of infants unable to express their agony while going through this phase" (fricker & segal, 1978, p. 366). currently, many doctors believe that saving these infants takes precedence over "abstract concepts of rights and autonomy" for women (steinberg, 1994, p. 17).

however, the only specific effect of maternal narcotic use is infant withdrawal, and not all infants exposed prenatally to narcotics experience symptoms of withdrawal. in one early canadian study 68 percent of the babies exposed prenatally to drugs experienced withdrawal symptoms, and further studies have found no correlation between severity of withdrawal symptoms and length of maternal drug use, daily dose level or time of last dose before birth (fricker & segal, 1978, p. 362). one recent canadian publication reported that as many as 75 to 95 percent of infants exposed to maternal drug use experience nas, which includes withdrawal symptoms (williams & bruce, 1994, p. 1475). u.s. studies claim that 60 to 90 percent of infants recently exposed to maternal drug use show signs of withdrawal (chasnoff, 1988b; householder, j., hatcher, r., burns, w., & chasnoff, i. 1982; stone et al., 1971). a few researchers have argued that infants can exhibit subacute secondary withdrawal symptoms from narcotics for up to six months after birth (chasnoff, 1988a, 1988b; committee on drugs, 1983; sunny hill hospital, 1992b), with a peak at six weeks after birth (chasnoff, 1988a, 1988b).
Any discussion of infant withdrawal is incomplete and biased, if it does not emphasize the fact that withdrawal is transitory and is not predictable (as not all infants exhibit withdrawal symptoms). The onset and duration of withdrawal varies even when the same drug is being studied in different infants. At the Women's Reproductive Health Service in Glasgow, of 200 babies born to women who used drugs during pregnancy only 7 percent required treatment for withdrawal symptoms, and fewer still were admitted to a special care nursery (Hepburn, 1993b, p. 54). The Liaison Antenatal Drug Service in South London noted that none of the infants seen was admitted to special care units after birth in the first year the service was established. The South London program, which saw only 35 mothers during that year, appears to have reduced withdrawal symptoms in their infants (Latchem, 1994, p. 486). In contrast, the number of infants requiring treatment for withdrawal in the U.S. and Canada has been cited as ranging from 60 to 95 percent of the total number of infants prenatally exposed to drugs. The question is, why is there such a large variance between percentages in the U.K. and North American studies? In Glasgow, Hepburn (1993b) has discovered that poor pregnancy outcomes "may be due not so much to the drugs as to the underlying socioeconomic deprivation or the effects of drug use on lifestyle" (p. 54).

Early research noted that there was difficulty in assessing whether obstetrical complications during the
pregnancies of women who used heroin were from the drug or from poor prenatal care, though maternal complications were low (Stern, 1966). Recent research in Liverpool notes that there are no differences in antenatal complications between opiate-dependent women and nondrug-using women (Siney, Kidd, Walkinshaw, Morrison, Manasse, 1995). Although numerous other short- and long-term effects have been attributed to maternal narcotic use, preterm delivery, low birth weight (Siney, 1995) and possible neonatal withdrawal symptoms appear to be the only direct effects of maternal narcotic use on the newborn (Hepburn, 1993a; 1993b; ISDD, 1992; Siney, 1994; Stone, et. al., 1971). However, as noted earlier, Siney et al. (1995) discovered that low birth weight was due to cigarette consumption rather than drug use, and Hepburn (1993a) states that preterm delivery outcomes are more likely to increase due to socio-economic deprivation than to drug use.

Lifschitz, Wilson, Smith, and Desmond (1985) note that when group means were adjusted for sex, race, prenatal care, weight gain during pregnancy, prenatal risk score, maternal education and maternal smoking, there were no longer any significant differences between infants exposed to methadone and heroin prenatally and drug-free infants. As well, after three years it was noted that the growth of the infants prenatally exposed to narcotics was no less than seen in control groups. Chasnoff (1988b, p. 276) also noted that studies that controlled for environmental factors found no
differences between children exposed prenatally to drugs and children who were not exposed prenatally although they had drug-using parents. Kaltenbach and Finnegan (1989) agree that there do not appear to be any developmental sequelae associated with prenatal exposure to narcotics, for these infants develop within normal ranges during the first two years of life.

Many symptoms attributed to maternal drug use are also observed in full-term, healthy children, such as difficulty self-regulating, hypertonicity (weak muscle tone), and respiratory difficulties (Weston, Ivins, Zuckerman, Jones, & Lopez, 1989). As mentioned earlier, cigarette smoking alone can cause low birth weight (Siney, 1994; Siney et al., 1995), and up to 90 percent of women studied for maternal drug use smoked cigarettes (Boer & Kreyenbroek, 1989). In addition, since the rise of modern obstetrics, women in labour are offered analgesics and narcotics for pain management. When drugs are legally prescribed by a physician we rarely question their effects on or possible consequences for the infant. Due to the natural birth movement in North America, drug-free deliveries have been requested by concerned parents, though most physicians and nurses have been resistant to such innovations. The ideology of "good" and "bad" drugs informs the beliefs and medical practices of health care workers.

In conclusion, findings of studies outside of North America (e.g., in Glasgow, where only 7 percent of 200 infants
exposed to narcotics experienced NAS symptoms) are quite different from those of North American studies, which claim that 60 to 95 percent of infants exposed to illicit drugs experience NAS symptoms. Outside of North America, it appears that offering nonjudgemental economic, social, and antenatal care to women who use illicit drugs during pregnancy results in pregnancy outcomes comparable to those of nondrug-using women, especially when midwifery care has been integrated into the program (Latchem, 1995; Hepburn, 1993a, 1993b; Siney, 1994, 1995; Siney et al., 1995).

**Cocaine Use in Pregnancy**

Cocaine-related difficulties during pregnancy were first reported by Acker, Sachs, and Tracey in 1983. An increase in placental abruption (Acker et al., 1983) and neurobehavioural abnormalities in infants (Chasnoff, Burns, Schnoll, & Burns, 1985) were attributed to maternal cocaine use. As well, an increase in prenatal morbidity and sudden infant death syndrome were noted (Chasnoff, 1988b). The most common effects noted in medical research include intense vasoconstriction (reduced oxygen supply due to blood vessel constriction), which contributes to low birth weight, small head circumference, and increased risk of premature birth. Teratogenic effects, birth anomalies and developmental and behavioural problems have also been cited. Finally, infants have been found to be irritable and difficult to care for, and failure to attach or bond has been observed.
One American doctor familiar with the pharmacological effects of drugs states that:

New on the scene is the epidemic of babies that have been born of mothers who used high doses of cocaine during pregnancy. Some are born with visible birth defects, but, in most, the defects are neurological and more difficult to detect. Nearly all these infants are irritable, tremulous, and difficult to soothe. Returned to a drug environment and possibly to poverty, newborns experience little physical or emotional nurturing, so bonding is incomplete or absent (Julien, 1992, p. 120).

In addition, Julien (1992) discusses the concern in the U.S. related to the formation of a "bio-underclass" of children damaged beyond repair due to maternal cocaine exposure. The above quote typifies much of the information available concerning the effects of maternal cocaine use. Julien (1992), emphasizes the "objectionable environment" in which infants prenataally exposed to drugs are raised.

Subsequent research has challenged many early claims of life-threatening problems in infants prenataally exposed to cocaine (see Chasnoff, Griffith, Freier, & Murray, 1992; Frank & Zuckerman, 1993; Greider, 1995; Hawley & Disney, 1992; ISDD, 1992; Lindenberg et al., 1991; Matthews, 1993; Mayes et al., 1992; Myers et al., 1992; Robins & Mills, 1993). For example, the incidence of placental abruption is controversial (Lindenberg et al., 1991; Robins & Mills, 1993). Hepburn (1993a) noted that higher incidences of placental abruption did not occur in her Glasgow study, nor did other obstetric complications often cited in relation to prenatal drug use.
Furthermore, the association between Sudden Infant Death Syndrome (SIDS) and maternal cocaine use is not firmly established (Hepburn, 1993a; Humphries, 1993; Mayes et al., 1992). Brown and Zuckerman (1991) state that recent studies show no increased risk or "slightly elevated risk," which may be associated with socio-economic deprivation (p. 563). Hepburn (1993a) has not found major increases in perinatal morbidity due to maternal drug use, including cocaine use.

Infants exposed to cocaine prenatally are said to have low birth weight and small head circumference. However, Brown and Zuckerman (1991) note that "this effect on growth is probably compounded by maternal undernutrition and poly-drug abuse" (p. 561), which could include the use of cigarettes and alcohol (Mills & Robins, 1993). Importantly, the large majority of infants exposed to cocaine prenatally are not low birth weight (Robins & Mills, 1993; Myers et al., 1992). Numan et al. (1994) study of 23 cocaine-exposed infants and their adopted mothers, and 23 matched control children not exposed to cocaine and their adopted mothers, suggests that prematurity and smaller head circumference may be due to intrauterine cause rather than environmental factors. However, further research is needed in order to determine the validity of their claims due to their small sample size and the exclusion of factors related to the mother's age and the adoption process which may be significant.
Prematurity is associated with low birth weight, but the majority of infants exposed prenatally to cocaine are not premature (Myers et al., 1992). As well, infants with low birth weight may be tested for maternal drug use more often than infants born within the range of normal birth weight, which would bias findings (Robins & Mills, 1993). Brown and Zuckerman (1991) also note that mothers who tested negative for urine toxicology at the time of birth, but reported having used cocaine during their pregnancies, did not give birth to infants with low birth weight. Shorter body length of infants exposed prenatally to cocaine is attributed to their mothers' drug use, but may actually be caused by maternal undernutrition (Brown & Zuckerman, 1991).

**Cocaine Withdrawal (NAS)**

Infants exposed to cocaine prenatally do not experience withdrawal symptoms as frequently claimed by the popular press. In fact, there is controversy over whether withdrawal occurs at all. Some researchers state that withdrawal symptoms include irritability and restlessness (Chasnoff, 1988b). Even in the U.S., where poor mothers lack prenatal, economic, and social support, it is reported that only one out of three infants prenatally exposed to cocaine experience any adverse effects at birth or later (Kusserow, 1990). These adverse effects can include sleep disturbances, irritability and complications due to prematurity. Still, it is impossible to make a direct correlation between the mothers' cocaine use
during pregnancy and the infants’ symptoms (Myers et al., 1992).

While it is still controversial whether infants exposed to cocaine may experience withdrawal, certainly the specific effects noted in infants experiencing opiate withdrawal are not evident (Hepburn, 1993b; Myers et al., 1992; Morrison & Siney, in press). Nor is there evidence to support long-term sequelae in infants experiencing withdrawal symptoms due to maternal drug use (Hepburn, 1993a). Many studies detect no differences between infants exposed to cocaine prenatally and nonexposed infants. However, these studies have not been readily available in professional journals. Koren, Graham, Shear, & Einarson, (1989) discovered that studies that found no difference in cocaine-exposed infants and nonexposed infants were rejected for presentation at scientific meetings and conferences, and by journals, more often than were studies which supported the incidence of adverse effects in infants prenatally exposed to cocaine. This practice ignores the superior methodology used in the studies demonstrating no difference between the two groups of infants. Evidently, the ideology surrounding NAS and illicit drug use is so entrenched that conflicting empirical evidence is disregarded by the scientific community.

Neurobehavioural and Congenital Abnormalities

Neurobehavioural abnormalities or dysfunction have been attributed to maternal cocaine use. But polydrug use and poor
prenatal nutrition can also contribute to neurobehavioural dysfunction (Brown & Zuckerman, 1991). In addition, findings of neurobehavioural abnormalities or dysfunction have been inconsistent (Zuckerman & Bresnahan, 1991). Although writers state that maternal cocaine use can cause congenital anomalies in infants (Hoyme et al., 1990), no consistent syndrome has been discovered (Brown & Zuckerman, 1991; Greider, 1995; Mills & Robins; 1993; Morrison & Siney, 1995).

**Long-term cognitive and behavioural problems**

In Amsterdam, van Baar (1991, 1992) conducted a study of infants of drug-dependent mothers (IDDM). Thirty-five children prenatally exposed to drugs (which included exposure to combinations of methadone, heroin, cocaine, amphetamines and tranquillizers) and 35 children whose mothers had not used drugs during pregnancy were studied to obtain information on the children's health, growth and neurological, cognitive and socio-emotional development. Both groups were studied for five and a half years. In terms of group differences, as opposed to individual differences, van Baar (1992) discovered that within the first two and a half years there were no differences between the two groups of children in health problems, neurological and motor development or cognitive development, including language understanding and speech. All of the study children showed secure attachment. Moreover, the children exposed prenatally to drugs did not display ambiguous or
avoidant behaviour, and were not different from the "nondrug" children in temperament (van Baar, 1992, pp. 5,6).

However, by three and a half to five years of age, several group differences were noted, including delay in cognitive development and behavioural problems, and all of the IDDM children weighed less and had lower height and smaller head circumference than the reference group throughout the study. It is impossible to determine from this study which developmental problems were due to maternal drug use (including cocaine use) and which were due to biological determinants and social circumstances. This is especially true since the mothers and children in the "nondrug" group lived in better social circumstances than the IDDM children (van Baar, 1992, p. 7). The fact that many of the cognitive development and behavioural problems did not surface until the children were between the ages of three and a half and five years old suggests that social environment is more significant than maternal drug use in cognitive development and behavioural problems.

Behavioural problems are often associated with children prenatally exposed to cocaine. However, critics state that it is not yet possible to determine whether behavioural problems are caused by maternal drug use (Hepburn, 1993b; Mayes et al., 1992), as studies do not take into account exposure to other drugs, genetic liabilities and prenatal liabilities (Robins & Mills, 1993, p. 18). Many of the behaviours that researchers
describe in infants exposed to maternal drug use are identical to behaviours found in "unusually small babies" (Robins & Mills, p. 18). Infants exposed to cocaine prenatally are often said to be recognizable by their behavioural differences and their "unreachableness" in interpersonal relationships. But Robins and Mills (1993) note that children exposed to drugs are no different from other children from economic and socially deprived backgrounds (p. 29). And Hawley & Disney (1992) point out that children who remained with their biological mothers were securely attached. There is no information about children exposed prenatally to cocaine whose families were not identified through welfare agencies (Hawley & Disney, 1992), and those children outside of the welfare system may have no identifiable problems.

A Canadian study by Nulman et al. (1994) of 23 adopted children whose biological mothers had used cocaine during pregnancy suggests that the children had lower expressive and verbal comprehension scores on the Reynell language test than did the control group which consisted of children of similar socioeconomic status who had not been exposed to maternal cocaine use. However, other research claims that maternal cocaine use has no effect on either I.Q. or neurological development (Robins & Mills, 1993, p. 19). Other suspected long-term effects involving developmental delay are unsubstantiated (Hepburn, 1993b). Chasnoff's longitudinal study of infants exposed to maternal cocaine use suggests that
they develop within normal ranges (Chasnoff et al., 1992). In addition, in Liverpool, infants exposed prenatally to cocaine have not exhibited the severe problems identified in the U.S. (Matthews, 1993). Patterns of use, access to health services and less deprived conditions may contribute to this (Noble, 1993).

Infants who have been exposed prenatally to cocaine have been said to be permanently affected by their mothers' maternal drug use. But "predictions of an adverse developmental outcome for these children are being made despite a lack of supportive scientific evidence" state Mayes, Granger, Bornstein, and Zuckerman (1992, p. 406). Maternal cocaine use is unlikely to be the cause of so many unsubstantiated effects on infant health. Myers et al. (1992) conclude, "the simple truth at this point is that we do not yet know what the effects are of prenatal cocaine exposure" (p. 1). There is no known syndrome related to prenatal exposure to cocaine that produces a set of recognizable physiological and mental deficiencies. According to Myers et al. (1992), there are "no published studies of middle- and upper-class cocaine-using mothers and their infants. Rather, low-income women make up the study populations. This means that the conditions of poverty get mixed up with effects of cocaine exposure" (p. 4). Although adverse effects of prenatal cocaine exposure are presented in the literature, the majority of infants exposed to cocaine prenatally are not impaired
Many of the problems associated with maternal drug use have nothing to do with a specific drug's pharmacological action, but are related "to the way they are used, the illegality of their use and other adverse factors predisposing to or resulting from drug use" (Hepburn, 1993a, p. 54). Cocaine is not the monster claimed by the press and the majority of scientific studies. Rather, it is one variable among many that influences maternal outcomes. So far it has been impossible to isolate maternal cocaine use from other variables that affect pregnancy outcomes, such as poverty (Myers et al., 1992).

IV. THE MEDICALIZATION OF MATERNAL DRUG USE

The infants of women who use illicit drugs during pregnancy are seen as a challenge to the medical, social service and legal professions in North America (Sweeney, 1989). This view ignores empirical evidence from other countries demonstrating that appropriate services for maternal drug use and NAS can be achieved by creating nonjudgemental antenatal and midwifery care that is cost effective and successful (Hepburn, 1993a, 1993b; Latchem, 1994; Siney, 1995). Numerous North American studies reveal the increasing medical cost of caring for NAS infants (Robins & Mills, 1993; Hawley & Disney, 1992; Committee on: Substance Abuse, 1990; Howard et al., 1989), the increasing cost to foster care (Hawley & Disney, 1992; Howard, Rodning, Kropenske, 1989; Weston et al., 1989) and increased costs related to
involve ment in the criminal justice system (Howard et al., 1985). One California prosecutor states that crack children are going to grow up to "be a new class of criminal" - criminals without a conscience (Gómez, 1994, p. 151).

Many physicians claim that the management of "pregnant addicts" and their newborns are a challenge to society (Stone et al., 1971, p. 720), though a challenge that should and could be handled by any "modern obstetric service." Kandall (1991) notes that physicians have never before been asked to predict the future of drug-exposed infants. Other factors outside of drug use might adversely affect each infant and Kandall (1991) warns that it will be difficult to isolate drugs from other variables that are associated with poor infant outcome.

The medical community has contributed to the social construction of NAS and illicit drug use. Physicians claim that they are the legitimate experts capable of handling NAS and the maternal health of women who use illicit drugs. They say the management of these women can be improved through modern medical technological interventions such as fetal monitoring and ultrasound (Gómez, 1994) urine screening and meconium screening of infants. In short, illicit drug use during pregnancy is perceived as a medical problem, rather than a social problem. Links to the social environment are often ignored, rendering social change irrelevant.

Risk Assessment
Risk labels are an integral part of the medical model of maternal health. Risk labels are intended to draw attention to populations that have poor maternal outcomes and to provide specialized medical attention to them. However, medical professionals assume that the language of risk is objective, as all scientific thought is believed to be. Risk categories are social constructions which are both artificial and unreliable, and labelling women and infants "at risk" can have dire psychological and social consequences, especially when medical intervention removes the mother and infant from their social support systems at a time when these are needed most (Wagner, 1994).

Oakley's (1992) study of women who gave birth to low-birth weight infants shows how diagnostic risk assessment may actually have negative effects on maternal well-being and how women differ from medical professionals in their assessments of risk. Saxell (1994) demonstrates how women differ from the medical model in their assessments of risk in pregnancy. All of the women over 35 years of age interviewed in Saxell's (1994) study rejected the notion that they were at high risk due to their age. In contrast, the obstetrical literature clearly defines them as "at risk." The women in Saxell's (1994) study agreed that high-risk labels could have a negative impact on pregnancy, altering maternal outcomes. Currently, there are no medical risk-assessment systems that
include the perceptions of the mothers themselves (Oakley, 1992).

Pregnant women want continuity of care during pregnancy that is supportive, sympathetic and provided by other women. Indeed, it appears that this type of support is more effective than medical interventions during pregnancy (Oakley, 1992). Furthermore, woman-centred midwifery support is both safe and inexpensive (Burtch, 1994; Hepburn, 1990; Saxell, 1994; Siney, 1994, 1995; Wagner, 1994). Successful maternal services for women who use illicit drugs have striven to normalize pregnancy and birth (Siney, 1994, 1995; Hepburn, 1990, 1993a, 1993b).

Aside from the differences in subjective opinion about who is at risk and the protocol that emerges from an "at risk" assessment, labelling women high risk becomes problematic when women refuse or are unable to change their "at risk" behaviour. Due to the social construction and labelling of women who use drugs during pregnancy as "high risk," women who are unable to stop using drugs or who do not want to stop using drugs during pregnancy are perceived as failing to comply with medical advice. This may have adverse consequences for women. The label of high risk for women who use drugs during pregnancy has not led to more resources or support for mothers. Rather, it has served to reinforce unequal power relations between medical professionals and mothers.
As well, labelling infants high risk has led to the isolation and separation of infants from their mothers through lengthy confinement in hospital, social service apprehension in Canada, and criminal charges and incarceration of mothers in the United States. The label NAS is recorded on public health and school records and on foster care and adoption lists. The child and parent are stigmatized regardless of whether the label is correct. Unfortunately for mothers and infants, when medical practitioners assess risk they are usually overly cautious, and rarely remove high-risk labels even if evidence to the contrary is present (Handwerker, 1994).

A recent study examined the different reporting of Neonatal Opiate Withdrawal (NOW) in England and Wales (Morrison & Siney, in press). Data was collected at maternity units about NOW assessment charts which list risk factors, drug treatment of withdrawal symptoms, and referral systems. One hundred and ninety-one questionnaires were returned and it was discovered that eight different NOW assessment charts were being used by maternity units. The list of symptoms attributable to withdrawal varied on each NOW assessment chart and different drugs were given to infants to manage withdrawal symptoms. Morrison and Siney (in press) note that many of the NOW symptoms listed on the assessment charts are subjective; in addition, many of the symptoms listed are exhibited by infants who have not been exposed to maternal drug use.
Nevertheless, all symptoms exhibited by infants who are being monitored for NOW symptoms are "often automatically attributed to withdrawal" (p. 6). The researchers list a number of medical problems - such as metabolic abnormalities, and mild cerebral irritation caused by foetal hypoxia and instrumentally assisted deliveries - that can mimic withdrawal symptoms in the newborn infant. It was discovered that many of the maternity units used the assessment charts for infants exposed to other (nonopiate) illicit drugs, even though there is no empirical evidence to suggest that withdrawal occurs. In summary, the risk assessment and care of infants exposed to maternal drug use is often subjective and inappropriate, and sometimes (when not clinically indicated) discriminatory.

Siney (1995) has developed a NOW chart and instructions for treatment which is in use in Liverpool (see Appendix F). Siney's (1995) chart and instructions for treatment appear to be more objective in determining whether an infant is truly exhibiting withdrawal symptoms and more effective in treating withdrawal symptoms. Siney (1995) also discusses the identification of women who use illicit drugs during pregnancy and their infants as "high risk" by medical professionals. She concludes that the majority of maternal drug research comes from the U.S., where there is no access to health care for poor people, and that social deprivation is linked to poor maternal outcomes.
The debate surrounding risk categories reveals the differences and assumptions underlying two models of health: the medical model and the social model. According to the medical model of health, pregnancy and birth are a medical problem where medical intervention is necessary to decrease risk of pathology and death (Wagner, 1994). The social model of health perceives birth as a biosocial process that is part of the daily fabric of life. In addition, the social model of health considers social factors that affect maternal outcomes, such as poverty, poor nutrition, lack of housing and lack of social support. Wagner (1994) notes that there is no effective medical intervention that will improve low birth weight (one of the variables associated with maternal illicit drug use), as factors related to low birth weight are social.

Handwerker (1994) discusses the tension that is currently evident between pregnant women and medical professionals who wish to instruct women to change their behaviour during pregnancy. She points out that pregnant women are unable to predict which behaviours will carry criminal penalties in the U.S. This contributes to the prosecution of women in the criminal justice system for failing to comply with doctors' wishes, especially in the case of poor women who use drugs. In the U.S., it is increasingly women identified as drug users at public health clinics and hospitals, rather than private patients, who are later prosecuted for child abuse and neglect.
Judges in both Canada and the U.S. are now asked to assess risk in these cases and medical evidence is presented as if it is scientific fact rather than a social construction (Gómez, 1994; Handwerker, 1994). Due to the assumption that parents are unable to care for infants labelled "high risk," doctors are called in to testify in family court cases involving child apprehension by social services. The mother is perceived by the prosecutor as antagonistic to the fetus and to fetal outcomes. This trend encourages women to avoid medical care during pregnancy for fear of being identified as "at risk" and made vulnerable to criminal prosecution in the U.S., and child apprehension in both Canada and the U.S.

Cultural Differences

Nugent (1994) examines how concepts of "risk" and "normality" are cultural constructions which may not be valid outside of the culture in which they were constructed. Cross-cultural studies have emphasized this discrepancy and the negative effects of placing one's own cultural values on other communities who may not share the same values or practices. Socialization is not static. It is an interactive process, a co-construction wherein the behaviour of the infant contributes to shaping the behaviour of the parent as well as the other way around (Nugent, 1994, p. 4.) This has been extremely important in the areas of maternal health, child care and child development. Nugent (1994), and Dreher, Nugent, and Hudgins (1994) have demonstrated in their examinations of
maternal marijuana use in Jamaica, risk status of unmarried mothers and their infants in Ireland and sleep environments and sleep disturbance in infants in Japan that medical models of risk are cultural constructions. The researchers discovered the exact opposite of what their previous experience had led them to suspect. For example, Nugent et al. (1994) notes that U.S. medical data suggests that infants are negatively affected by maternal marijuana use; therefore, they expected their research on maternal marijuana use in Jamaica to have similar results. As noted earlier, this was not the case, in fact, the Jamaican mothers who used marijuana heavily during pregnancy had healthier babies than women who were light users or nonusers of marijuana (Dreher et al., 1994; Nugent et al., 1994).

In summary, models of risk are cultural constructions. Risk categories must "emerge" from the communities they serve (Nugent, 1994); otherwise they may cause harm by increasing medical attention, intervention and treatment that is unwarranted and unwanted (Alexander & Keirse, 1989).

Oakley (1992) reveals how smoking encapsulates the cultural problems surrounding women, motherhood and risk. As noted earlier, it has consistently been suggested that smoking in pregnancy places infants "at risk" due to the adverse association between smoking and low birth weight. Women are instructed by health professionals to quit or reduce smoking during pregnancy. However, this logic fails to encompass
specific social factors related to smoking. Smoking in pregnancy is "associated with conditions of material disadvantage, with social stress, anxiety and indices of low control over living conditions, and with low levels of social support" (Oakley, 1992, p. 320). Thus, smoking in itself is not irresponsible. Rather, it may be a way for women to cope with the stresses of their domestic environments and to continue caring for their families (Oakley, 1992).

As early as 1981 Rosenbaum noted that women who used heroin in the United States believed that their duties as mothers were their greatest responsibility, and their "single claim to worthiness" (p. 100). Like non-drug-using women, women who use illicit drugs subscribe to the ideology of mothering that prevails in Western society. Both Goode (1994) and Taylor (1993) note that women who use illicit drugs do so to cope with the stress of their family lives and to gain a sense of control over their situation. Nevertheless, medical studies and policies continue to address the use of licit (including tobacco) and illicit drugs during pregnancy as a matter of the mother's ignorance about the adverse effects of smoking or unwillingness to stop regardless of the health of the developing fetus. "At risk" categories ignore the constraints of one's social environment on achieving optimum maternal health. Maternal health is discussed as an individual choice of the mother, rather than as an outcome of the mother's social environment.
Rather than examine the social context of women's lives, health professionals question whether mothers exhibit a responsibility to their developing fetuses and whether they have followed medical advice. Medical advice ranges widely. Women may be told to eat nutritional food, cease drug use, get bed rest, abstain from physical activity and exercise. This advice usually ignores the social context of the mothers' lives. Mothers in the U.S. who have been identified for criminal prosecution have overwhelmingly been poor women and women of colour. The U.S. continues to have the highest infant and maternal mortality rate of all industrialized nations, and technological advances have not been able to improve maternal health for most women in the U.S. The ultimate question is whether improving maternal health care lies within the scope of the medical model of care. Economic and social support appear to be the most significant variables in improving maternal and infant health. Historically, health professionals have ignored the evidence that "social interventions promote physical health" (Oakley, 1992, p. 325).

V. SUMMARY OF RESEARCH ON MATERNAL DRUG USE

In 1982 Householder et al. noted several methodological problems in research on prenatal exposure to drugs. These include lack of control for polydrug use and maternal health variables, lack of randomization in the selection of research subjects, lack of universal criteria for measuring infant withdrawal and failure to meet standards of scientific
experimental design (pp. 463-464). Experimental designs failed to include control groups and to provide adequate analysis of data. They implied causal interpretations despite the lack of random selection and manipulation of independent variables. They failed to provide empirical data confirming behavioural and psychological consequences of maternal "addiction." Finally, there was a lack of longitudinal studies (Householder et al., 1982, p. 464-465).

Research today continues to exhibit methodological flaws (Frank & Zuckerman, 1993; Lindenberg et al., 1991; Mayes et al. 1992). The study of prenatal exposure to drugs has been anecdotal and based on small study populations (Frank & Zuckerman, 1993; Lindenberg et al., 1991; Mayes et al. 1992). Myers et al. (1992) point out that research on prenatal exposure to cocaine still fails to include randomization of selection of research subjects, fails to include middle- and upper-class women and infants in study populations, confuses the effects of poverty with drug effects, often selects women in drug treatment centres for study populations, fails to control for children's environments in influencing outcomes and fails to "establish frequency, quantity, quality, type, and timing of substances used" (p. 4). Many studies pertaining to child development of infants exposed prenatally to drugs still lack adequate control groups (Mayes et al., 1992). As well, most studies only included children in foster care,
rather than children residing with their mothers (Householder et al., 1982; Lindenberg et al., 1991).

Another limitation on the validity of research on neonatal and maternal illicit drug use is the reliance on governments for funding. In Canada, we are influenced by U.S. law, policy and research (see Chapter two). Most of the studies on maternal drug use and prenatal drug exposure originate in the United States. Gómez (1994) states that government-funded research in the U.S. is limited in two ways: "the particular context of government funding for drug research and prenatal drug exposure as a subset of that category; and...the government's anti-abortion policies under the Reagan and Bush presidencies" (p. 28). She explains that there are incentives to discover a "bigger problem," for government funding relies on the existence of a "problem" and the researcher as problem solver. Consequently, the larger the problem, the larger the funding (Gómez, 1994, p. 28-29). The U.S. government's pro-life policy, which has resulted in cuts in funding for family planning, abortion information and public health agencies and increased funding for studies on fetuses and infants, contributed to limitations on valid research (Gómez, 1994, p. 29). Gómez points out that this pattern of funding can be recognized when observing AIDS research in the United States. Forty percent of government funding goes to paediatric AIDS research, although children
comprise only 2 percent of all AIDS cases (Gómez, 1994, p. 29).

One final factor that affects research on maternal drug use is the lack of research on levels of frequency of use. Attempts to discuss levels of use are often perceived as condoning drugs and establishing set limits of safety, which is prohibited (ISDD, 1992). This is obvious in the case of FAS, since there is no clear level of harm to the fetus. Yet women are warned to not drink at all during pregnancy. The medical profession prefers to "play it safe," rather than to strive for more accurate findings.

Proposed research on maternal drug use appears to have as many flaws as past research. As mentioned earlier, writers often suggest techniques for gathering information that may be illegal or unethical and may infringe on human rights and civil liberties. After reviewing the literature on prenatal exposure to illicit drugs, Robins and Mills (1993) suggest future research to improve our understanding of this issue. They note several gaps in existing research and plan to investigate these gaps in their recommended research program. They state that future research programs are hindered due to several factors: women's reluctance to admit illicit drug use; likelihood of heavy users to experience psychiatric difficulties, which make it difficult for them to collaborate in research projects; the difficulty of distinguishing the effects of illicit drugs from other compounding factors; the
difficulty of ascertaining pregnancy sufficiently early; and the lack of cooperation from medical, drug treatment and social agencies in obtaining information.

Robins and Mills (1993) conclude that in order for these gaps in knowledge to be filled, legal changes need to take place. Although the legal changes they propose are quite radical, they are placed in the Appendix of their journal article, rather than in the text. The authors suggest that the U.S. Congress adopt a law giving "bona fide researchers" access to medical records, school records and vital statistics, in the absence of permission from either the individual or the state. It is proposed that this may help in the search for information regarding the "serious social problem of perinatal drug use and help the women and children who are affected by the drug epidemic" (p. 32). Surprisingly, in light of the legal changes they advance, Robins and Mills (1993) state that despite a long list of possible problems associated with prenatal exposure to illicit drugs "most of the births are unremarkable" (p. 18).

All that appears certain is that exposure to most drugs results in growth retardation, which is probably at least in part a consequence of maternal malnutrition. Although drugs are suspected of contributing to cerebrovascular accidents and genitourinary malformations, evidence is weak (Robins & Mills, 1993, p. 25).

Ignoring the above claim, Robins and Mills insist that further information is needed. They advocate that more intrusive research methods be utilized where the "burden on individual
privacy would be very light, whereas the anticipated benefits of new scientific information on the effects of perinatal drug use would be very great" (p. 32). They conclude that:

one could argue that the researcher’s interest in understanding more about the consequences of in utero drug exposure for the benefit of other children ought to take priority over the mother’s wish for privacy (p. 29).

However, the question of who benefits from scientific interest is debatable. Scientific interest is not always in the best interests of either women or children. The presumption that information derived through infringements on individual privacy will benefit society is, at the very least, suspect. The right to privacy is often illusory, especially for women who are poor and marginalized. The social construction of NAS fuels this type of interest and policy.

In light of the fact that their own conclusions found little direct link between maternal drug use and adverse effects on the infant, why is there a need for further research on adverse effects using methods that are currently illegal and unethical? Why is there so little social science research examining the lack of correlation between maternal drug use and adverse effects on the infant? Finally, why are articles that show little or no difference between prenatally exposed infants and nonexposed infants unpublished?

In contrast to the majority of research, a growing body of research questions the prevailing urgency of labelling prenatally cocaine-exposed infants as permanently damaged
(Frank & Zuckerman, 1993; Greider, 1995; Kandall, 1991; Mayes et al., 1992). Mayes et al. argue that labels are self-fulfilling and may bias and undermine clinical decisions and scientific publications. Labelling and isolating infants and children due to prenatal exposure to illicit drugs is "irrational and inhumane":

Studies of preterm or ill newborns fail to support biologic determinism. Environments contribute significantly to the outcome of infants with biologic vulnerabilities at birth. Even among infants exposed to narcotics prenatally, the home environment, and not the amount of narcotics, seems to be the more important predictor of developmental outcome (1992, p. 407-408).

Following their reasoning, would it not be more appropriate to divert further research funding for prenatal exposure to illicit drugs to parents who could benefit from economic support to create more viable home environments?

Conclusion

Research claims that getting pregnant women to prenatal care and medical services is problematic. Often mothers arrive in hospital at the time of delivery without having ever attended prenatal care. However, Siney (1994) states that the primary reasons why pregnant women who use drugs fail to attend prenatal services prior to delivery are related to their fears of social services involvement and scrutiny of parenting and lifestyle, lack of confidentiality, and segregation and isolation by medical professionals (p. 229). It is well documented that when pregnant women are offered nonjudgemental, comprehensive prenatal care and infant follow-
up, maternal outcomes have improved. This is so in spite of "high risk" categories and socio-economic status (Hepburn, 1993a, 1993b; Higgins et al., 1989; Latchem, 1994; Lazarus, 1988; Siney, 1994, 1995; Siney et al., 1995). Furthermore, the data consistently suggest that social environment is just as important, or more important, in infant development as prenatal exposure to drugs (Chasnoff et al., 1992; Dreher et al., 1994; Kaltenbach & Finnegan, 1989; Lifshitz et al., 1983; Lifshitz, Wilson, Smith, & Desmond, 1985; Nugent, 1984).

In conclusion, research findings suggest that drug use is only one factor of many influencing pregnancy outcomes. The legal drugs alcohol and tobacco appear to be more dangerous to infants than illegal drugs. These findings also illuminate the differences discovered between research findings in the United States and countries that have different socio-economic environments and drug legislation. In light of the research available, Neonatal Abstinence Syndrome appears to be a cultural fabrication.
CHAPTER 5 - Theory To Method

Introduction

Most feminists contend that choosing a research method is a political decision (Kerby & McKenna, 1989). For the purposes of this research, in order to bring forth the opinions of women who use illicit narcotics, a feminist perspective will inform the dissertation. The following sections will examine critical feminist research and method, the research design, access and ethical considerations, the significance of the research, limitations of the research, field work, the interviews and coding.

I. CRITICAL FEMINIST RESEARCH METHOD

The traditional mainstream view of social science has been informed by positivism, which can be traced to the mid-to late-19th century. Early social scientists sought to make the social sciences worthy of the title "science" (Palys, 1989). Central to positivism is the conception of the scientific method, modelled on the natural sciences. This method embraces deductive logic, which emphasizes experimental and survey research and quantitative (deductive) forms of analysis (Hammersley & Atkinson, 1983). The central concepts are universal laws, explanation, reliability, validity (Abrahamson, 1983; Hughes, 1976; LeCompte & Goetz, 1982; Phillips, 1971). The world was perceived as being ordered in patterns which could be described by the human observer (Abrahamson, 1983).
Positivism was considered to be value neutral, meaning that one could retrieve and understand causes without reference to subjectivity (Schwartz & Jacobs, 1979). Scientific methods were to protect against the contamination of subjective ideas of researchers (Gouldner, 1965; Jayaratne & Stewart, 1991; Reinharz, 1992). In contrast, feminists and other critics argue that positivism emphasizes male distance and objectivity (Harding, 1991). To be scientific is to be dispassionate and impartial. Jackson (1987) states that "there is no such a thing as a neutral observer. We choose our subjects, our instruments of measurement, our questions" (p. 294). Science has generated information and technologies that are not morally or politically neutral (Harding, 1991). It is a myth "that social science should and could be value-free" (Gouldner, 1965, p. 196).

Feminists argue that objectivity can be both hierarchical and controlling (Jayaratne & Stewart, 1991); it fails to address the meanings of people's actions (Phillips, 1971), because it leaves the personal (subjective) outside of science (Jayaratne & Stewart, 1991). It also separates the observer from the object of study and reflects only one side of the research process and social reality - that of the more powerful "knower" (Acker et al., 1991).

Feminists argue that positivism has been both sexist and elitist in its lack of women as research subjects and its selection of topics (Jayaratne & Stewart, 1991) which preserve
the existing social order (Oakley & Oakley, 1979; Reinharz, 1992). Male behaviour is considered objective human behaviour (Patai, 1983) and science reflects the male values of autonomy, separation, distance, and control (Jayaratne & Stewart, 1991; Reinharz, 1992). Harding (1991) notes that thinking about women's lives provides resources for reinventing the sciences. Without new sciences the majority of people remain "deprived of knowledge that could enable them to gain democratic control over the conditions of their lives" (p. 312). She calls for "less false beliefs," in contrast to the "truth," in trying to understand ourselves and others, and for designing liberatory social relations.12

Feminism is a perspective which embraces several elements (Jayaratne & Stewart, 1991; Reinharz, 1992). Foremost, feminist research insists on the value of subjectivity and personal experience and gender, race and class are perceived as basic features of all social life (Reinharz, 1992). A feminist perspective pays attention to the language of research, how topics are constructed and how the researchers reject positivism and its reliance on "truth," Harding (1991) argues that science is neither all bad nor monolithic, for it contains both progressive and regressive tendencies, as does feminism (p. 10). Beliefs have social causes; both the researcher and the research subject "are in the same social, political, economic, and psychological scientific planes" (p. 12). Feminists have been successful in developing new research methods, and reinventing traditional positivist quantitative methods. Quantitative research has a place one of many methods to be utilized when conducting feminist research. Positivist methods are neither inherently gender blind nor inherently oppressive.
researcher listens, edits and writes (Devault, 1990). It strives to represent human diversity, and to challenge and overturn traditional views of women, men and human society (Patai, 1983). Central to feminist research has been a focus on reflexivity, on exploring gender relations underlying the conduct of inquiry (Fonow & Cook, 1991) and on looking for relations that underlie everyday experience.

In short, feminist research embraces a dialectical method of inquiry which recognizes the relations that underlie everyday experience and the connections between the two (Acker et al., 1991, p. 135). Its aim is to create social change (Reinharz, 1992) and specifically to help transform women's lives (Jayaratne & Stewart, 1991). The researcher is part of the research (Smith, 1986; Stanley & Wise, 1979). Each interview is reflexive - a back and forth process that establishes rapport (Reinharz, 1992; Smith, 1986).

Hansson (1995) in discussing "progressive-realistic" criminology in South Africa, summarises grounding principles which also apply to the type of action-research being revived among U.S. and Canadian feminists. These principles articulate my own methodological ethos:

(a) non-exploitation of those who are researched or affected by research; (b) active sharing of resources, skills and information between researchers and researched, including direct assistance to the researched where appropriate; (c) accountability of researchers to the researched; (d) active participation in the research process by those who are researched, particularly through democratic consultation about what is to be researched, how it is to be investigated and what
is to be done with the knowledge that is produced; (e) the placement of researchers on the same analytical plane as the researched (Hansson, 1985, p. 46).

Feminists have methodological affinity with others who have written critically about drugs and who also value subjective experience. Such writers have examined the impact of race and class and the construction of language and have striven to overturn traditional views concerning licit and illicit drug use. However, until recently, they have failed to incorporate a gender analysis in their research.

In order to hear the subjective voices of women, I have chosen qualitative (inductive) research methods for this study. Open-ended interviews conducted have allowed for the movement from observation to theory and for an interpretive framework of analysis. I have also obtained biographical information such as age and education. Qualitative methods are not exclusive to feminists (see Glaser & Strauss, 1967; Jackson, 1987; Lofland & Lofland, 1984). Such methods focus on process and theory building, a process refined by Kirby and McKenna (1989), which builds on "grounded theory" by using constant comparisons and questioning (Glaser & Strauss, 1967; Kirby & McKenna, 1989; Strauss & Corbin, 1990). Grounded theory consists of a bottom-up, circular, up-and-down process where "interpretation underlies the entire research process" (Kirby & Strauss, 1989; p. 23). Researchers attempt to formulate theory during the research process, rather than having a prior hypothesis direct the research (Glaser &
Strauss, 1967; Lofland & Lofland, 1984; Strauss & Corbin, 1990). Feminists have adopted and extended qualitative research methods that emphasize triangulation or the combining of methods (Jayaratne & Stewart, 1991).

Given the lack of information concerning women's opinions about the institutions that often define and shape their lives, I have selected an interview format that facilitates the airing of opinion and the revelation of experience, rather than one that is centred on life history, ethnography or "career." Critical research differs from conventional research in that "it locates specific practices in a wider social structure in an attempt to dig beneath surface appearances. It addresses myths or contradictions as expressions of oppressive social structures" (Harvey, 1990, p. 14). As a researcher, I have no need to speculate on how the legal, social service and medical professions affect women who use illicit drugs. What is surprising is that, to date, few people have questioned illicit drug users about their opinions and suggestions.

regarding social policy, medical treatment and the laws that seek to regulate and control them.

II. RESEARCH DESIGN

My professional experience as a teacher, community support worker and counsellor to women over the last fifteen years informs my research. Unlike many researchers who choose to study a specific population I am well acquainted with many women who had used illicit drugs but were not visible users\(^4\). I am also familiar with the areas of highly visible sale, distribution and use of illicit drugs in Vancouver, B.C. Finally, I am aware of the diversity of illicit users as determined by class, race, expectations, social setting and drug of choice.

In contrast to those who conducted two of the three ethnographic studies of women drug users that exist to date (Taylor, 1993; Rosenbaum, 1981), I had no difficulty in deciding where or how to do my fieldwork. Having lived within a community where drugs were part of the daily fabric of life has given me experiential knowledge that no amount of preparation, fieldwork or reading could have provided.

\(^4\)"Visible users" refers to those women whose illicit drug use was known to social service and legal professionals. "Nonvisible users" refers to women whose illicit drug use was not apparent to such professionals. Visibility does not remain static; many of the women were not visible users at the time of the interview but had been in the past, when they were on social assistance or in contact with the criminal justice system. However, not all of the women who had ceased to use illicit drugs were successful in becoming less "visible." Factors that determine visibility include successful re-entry into conventional society.
Social science research rarely acknowledges the less problematic user, or the user outside of a visible street scene. This focus on problematic and poor users as the norm has biased social research. The invisibility of other drug users has made research outside of the street scene more difficult, but not impossible. When upper- and middle-class drug users are included (see Cheung et al., 1991; Erickson et al., 1987; Waldorf et al., 1991; Blackwell, 1983) it becomes apparent that many of the characteristics and attributes assigned to drug users by social researchers have nothing to do with the drugs, and everything do with the users' status in society (their class, race, and gender) and the illicit status of specific drugs. Hence my commitment to including interviews with women who were not visible drug users at the time of the interview.

My work with Drug and Alcohol Meeting Support for Women (DAMS) in the last three years has served to place the concerns of poor women attempting to exit a street lifestyle within the scope of this research as well. I am daily reminded of just how difficult it is for women to achieve any semblance of stability in their own lives in the absence of social and economic support.

DAMS is a nondiscriminatory group of women who meet to offer support to each other. Their format is an alternative to N.A. and A.A. DAMS is dedicated to harm reduction, self-empowerment, and helping to meet the needs of women and their dependents. Women self-refer to DAMS, or may be referred by other agencies. The majority of participants are from the Downtown Eastside of Vancouver, and most are mothers.

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DAMS was created in 1991 in response to requests for a women's self-help group that dealt not only with alcohol and drug concerns but also with issues of family violence, poverty, isolation, HIV and parenting. In contrast to an A.A. model, DAMS is concerned with stability rather than abstinence from drugs. However, many women include abstinence from drugs in their individual assessment of what they need for their own stability. My experiences with community services and with DAMS have made me critical of the kind of policy recommended by many researchers in this area. Services and policies that are client directed speak to the needs of the affected community, rather than the assumptions and needs of the researcher.

In addition to my field work with DAMS, I spent three weeks in Europe visiting programs for women who use illicit drugs, with a special emphasis on programs for mothers. I interviewed directors, employees and users of specific programs in Liverpool, Glasgow, Amsterdam and Rotterdam. The many services I visited served as a backdrop to this research project.

My study began with a survey and analysis of the existing literature on the topics of illicit drug use, reproductive autonomy and feminist research. I conducted several literature searches, including one through the Addiction Research Foundation under the headings "drug use and pregnancy" and "women and substance use/abuse." To broaden the scope of the
literature review, a literature search was made through the Institute for the Study of Drug Dependence (ISDD) under the headings "pregnancy/newborn" and "females." Finally, a library search was conducted at Simon Fraser University under the heading "women & drugs" and through Medline under the heading "cocaine and pregnancy."

After reviewing the literature, and consulting with colleagues and members of my dissertation committee, I developed 13 questions in response to specific gaps noted in current research (see Appendix D). My aim was to obtain the views of the women interviewed concerning the agencies and professions that seek to regulate them.

Upon receiving approval from the Ethics Committee (see Appendix A) I conducted two pilot interviews. I then began a series of semi-structured, open-ended interviews of one to three hours' duration. A major aim of the interview was to reveal the opinions of the women in the study regarding the agencies that regulate them. My subjects were adult mothers in Western Canada (British Columbia, Alberta and Saskathween) who have used illicit drugs.

I conducted a total of 43 interviews: 15 with professionals in the field and 28 interviews with women who were using or had used illicit drugs. Both sets of interviews were conducted simultaneously, so the numbering of the interviews ranges from 1 to 43, although only 28 mothers were interviewed. All of the mothers interviewed have been given
fictional names in the thesis in order to preserve their anonymity. The use of fictional names allows the reader to follow the women interviewed as the data chapters unfold (see Appendix G for composite profiles). The interview with the founding director of the Sunny Hill NAS program in Chapter seven is identified by a coded number. The women interviewed who used illicit drugs were chosen through a snowball sampling. I interviewed seven women I knew and asked each one whether she knew anyone else who would like to contribute to the research. Fortunately, the snowball sampling was quite effective in including women outside of the original social network.

None of the women were contacted at a clinic or in prison. Critical researchers in this field have noted that interviewing participants in prison and clinic populations may skew results (Waldorf, et al., 1991). People in prisons and clinics represent only a small minority of illicit drug users - the poor, the most visible and the most problematic. Moreover, captive participants may not be able to freely express themselves.

None of the participants was paid. The interviews took place either in the women’s homes or in mine. After the first seven interviews were completed I re-examined the interview format, made minor adjustments, noted consistencies and patterns in response and developed a coding schedule. In order to obtain a diverse cross section of women who use illicit
drugs I included women of different classes, ages, and races. All the women interviewed described themselves as being addicted or having a dependence on drugs, according to Alexander's (1990) continuum of involvement in drug use.

I interviewed only women who had used narcotics (opiate derivatives), and/or coca derivatives (cocaine, crack) for more than one year. The mean duration of use was 14 years. I had originally intended only to interview women who used narcotics (opiate derivatives), but I broadened my research in order to address poly-drug use and the phenomenon of "crack babies." Specifically, I have endeavoured to explore stereotypes and broaden the perspective of categories of drug users.

As mentioned above, I visited several community and health services for women who use illicit drugs (and for their infants), in Canada, Scotland, England, and the Netherlands. These contacts have created a framework for comparing different policies and treatments for women who use illicit drugs prior to and during pregnancy. Interviews with the directors of NAS, antenatal and birth programs inform Chapter 16Alexander (1990) introduces the term "continuum of involvement" to describe patterns of drug use. These include abstinence, experimental use, circumstantial use, casual use, regular recreational use, dependence and addiction (pp. 103,104). Drug use is not static and individuals can move within the continuum. Dependence refers to "diminished flexibility" towards a specific drug. Overwhelming involvement distinguishes addictive use from dependent use. Alexander (1990) states that "dependence may remain in the background of a person's life, but addiction is necessarily central and supplants other important activities" (p. 105).
four, which also presents discussion of treatment and care for mothers and infants.

**Ethical Considerations and Access**

Critical researchers have identified several areas of ethical concern (Becker, 1970; Platt, 1991; Thompson, 1993) and feminists have expanded on these discussions (Acker et al., 1991; Fonow & Cook, 1991; Reinharz, 1992; Stacey, 1988). My research is informed by their analyses.

I have concentrated specifically on four areas of ethical responsibility: providing a critical analysis exposing oppression (Kirby & McKenna; 1989; Platt, 1991; Thomas, 1993); knowing "whose side I am on" (Becker, 1970); acknowledging that research is not value-free (Diener & Crandall, 1978) and examining my own values (Lofland & Lofland, 1984; Reinharz, 1992).

The research has been approved by the Simon Fraser University Ethics Review Committee (see Appendix A). The research and data do not fall into the category of privileged communication under the law; however, all interview tapes have been destroyed after transcription in order to preserve confidentiality and anonymity. Each participant signed a detailed consent form listing the potential risks and benefits of the study and assuring confidentiality (see Appendix B). Due to the illegality of the drugs discussed, each participant was assured that there was no risk of conviction.
Women who had just given birth were excluded from this research. Although feminists have written about the recognition of "points of rupture" in social reality as loci for feminist research (Fonow & Cook, 1991), not all such moments are applicable for research. Women are very vulnerable during childbirth, which can be a time of biological and social transformation that may have far-reaching effects (Kitzinger, 1992, p. 1).

Stacey (1991) touches upon many of the ethical concerns that are prominent in my research, including a need to carefully separate from the interview data what one knows about the interviewee prior to the interview. I knew seven of the mothers prior to the interview. Having close relationships with participants may affect my interpretation of their voices (Fonow & Cook 1991; Stacey, 1991). With this in mind, I have attempted to frame my research questions in such a way as to create an interview format that is reflective as well as being informative for both the interviewee and the researcher. Feminists have noted the importance of consciousness-raising (Acker et al., 1991; Reinharz, 1992; Stanley & Wise, 1979); the interviews I conducted for this study have often been in themselves a journey of consciousness-raising, information-sharing and political activism.

Although feminist research strives to create a relatively equitable relationship between researcher and the interviewee, it is always the researcher who is in the position to
interpret and summarize the participant's words (Acker et al., 1991; Denzin, 1989; Jackson, 1987). For this reason, I have an ethical obligation to listen closely to what my interviewees say (Devault, 1990; Reinharz, 1992; Smith, 1986; Thomas, 1993), and to hear and acknowledge what might not fit into my original frame of reference (Glaser & Strauss, 1967; Kirby & McKenna, 1989; Strauss & Corbin, 1990).

Harvey (1990) states that after reading his book on critical social research, the reader "should never rest easy again" (p. 212). I hope my research will elicit a similar response. Researchers have an ethical responsibility to give something back to the communities or participants they work with (Reinharz, 1992; Thomas, 1993). It is my hope that my research will have an emancipatory outcome both for women who use illicit drugs and for their children through its dissemination to the agencies that regulate and control these women's lives. 

Rosenbaum (1981) notes that social science researchers are not welcomed generally into drug-using communities or into the homes of drug users. When a welcome is extended it is due to expected remuneration (p. 147). During the course of my research, I was asked by other researchers how I accessed my research population. I was told that illicit drug users were a difficult and unco-operative population, suspicious of outsiders, especially researchers. This was not my experience. There was an overwhelmingly positive response to my research.
Only financial and time constraints, led me to stop interviewing after completing 30 interviews (two were not included in this study because neither woman was dependent or addicted in her drug use).

Prior to conducting my research I contacted several women I knew who had used either narcotics or cocaine derivatives for more than one year in a dependent or addictive manner. I explained my research plan briefly and elicited their opinion on the research design. I asked whether they would be interested in participating in an interview in the future. All the women I talked to at that time expressed interest in the research and agreed to be interviewed. Most important to them, and to the rest of the women interviewed, was that I facilitate a forum for the women involved to express their views.

The majority of the women informed me that they had never been involved in any type of social research. No one had been involved in research concerning illicit drug use. The reason they decided to participate was the fact that I was familiar with their lifestyle. They assumed that I would be sensitive to their concerns, rather than voyeuristic. Every participant was aware of my own background and most brought my background up when introducing me to other participants within the snowball sample. My background is significant in that it may have elicited a wider range of responses than would otherwise have been obtained. As one woman stated:
Where you've been determines what I say to you and how I answer your questions. [Pat]^{17}

From this place the research project began.

III. SIGNIFICANCE OF THE RESEARCH

My personal background and my experience as an outreach worker familiar with illicit drug users drew me to examine the opinions of women who use illicit drugs. With few exceptions, the literature on women who use illicit drugs has painted a picture that seems stereotypical, moralistic and predicated on class, race, and gender biases. My own personal and professional experience was not reflected in the literature. Subsequently, I approached the research with many questions. Specifically, I wondered why men and women who use illicit drugs are rarely asked their opinions, and why men and women outside of prison and drug treatment centres are rarely interviewed. Is it true that these populations are difficult to access?

I was especially interested in revealing the thoughts and opinions of women who have traditionally been ignored in the literature on illicit drug use. I also wished to analyze the ways in which women who use illicit drugs are regulated and controlled through drug legislation and through medical and social service policies and practices. Women's ability to reproduce and their position as caretakers of the family have

\footnote{The quotations presented throughout this dissertation have not been altered in terms of style of speech. Fictional names are used to preserve the anonymity of all the mothers interviewed. See Appendix G for composite profiles.}
led to greater surveillance and regulation through medical and social service policy than has been practised on men. Therefore one of the major aims of this research was to explore how the women interviewed perceived the agencies that sought to regulate them.

Overall, this research will contribute to a framework for further feminist inquiry exploring social attitudes toward illicit drug use, the expanding network of control of female illicit drug use, mothering and reproductive autonomy. To date there is no information in Canada concerning how mothers who use illicit drugs view the law, social services and the medical profession. Nor has there been any critique by mothers of the services provided to them and their children. This research will explore these areas of concern.

IV. LIMITATIONS OF THE RESEARCH

There are several limitations to this study which I have recognized from the outset. Obviously, the data collected were limited due to constraints on time and resources. Only 28 women in Western Canada were interviewed and my findings cannot be generalized to other populations of women. This study provides only a condensed outline of the history of drug use and reproductive autonomy as a context in which to discuss the current phenomenon of women who use illicit drugs. It does not attempt to examine or analyze all historical accounts of drug use and reproductive autonomy in Canada. Rather it aims to integrate both disciplines and to draw from selected
historical research in order to provide a social and political context in which to ground the qualitative data obtained during the interviews.

As mentioned earlier, this study only includes interviews with women who have been dependent on/addicted to "hard" drugs (heroin or cocaine), for more than one year. It reveals individual differences in drug use, but does not include occasional users. The majority of women and men who use illicit drugs in Canada are occasional users and we have much to learn from their relationship with drugs.

Additionally, this dissertation deals only with mothers. Two of the aims of the research were to link the research on reproductive autonomy and mothering with critical analyses of drug use within a historical context, and to explore treatment models and services for infants labelled NAS. Therefore, I decided to interview only women who had given birth. This study does not attempt to link levels of illicit drug use with life events. Nor does it measure risk or how effective the women interviewed were as parents. Rather, this dissertation highlights the interviewees experiences in relation to the agencies that seek to regulate them.

Finally, this research includes only a brief discussion of the impact of AIDS on women who use illicit drugs. During the interviews the subject of AIDS was brought up briefly by two participants. I also was aware of several feminist research projects that address the issue of AIDS, such as that
conducted by Rudd and Taylor (1992), who present oral histories of women with AIDS, as well as medical information. This study and other studies effectively address the concerns of women living with AIDS.

V. FIELD WORK

Taylor (1993) notes that there are three kinds of risks involved in doing ethnographic research in the field of criminal involvement: legal, health and personal risks (p. 17). In fact, upon reading the list of precautions she took prior to conducting her research of female intravenous drug users in Glasgow, I wondered why I had never considered any of the risks she described.

On reflection, I realized that in terms of legal risk, I had no concern that I might be arrested or implicated in a drug charge. I did not contact the Vancouver Police, or the R.C.M.P. to inform them that I was conducting this research, for I did not perceive myself to be at risk. I was careful to transcribe the tapes quickly and to use coding to identify each woman, so the risk of arrest for them was negligible. Although past illegal activities were discussed during the interviews, none of the women exposed me to legal risk at the time of the interview.

Even though I am aware of the many health risks involved with drug use and especially with intravenous drug use, I did not feel at risk of infection. Most infections are spread through sexual contact or intravenous drug use, and I did not
participate in either activity during the fieldwork or interviews. I never once considered whether there was a personal risk to myself. Unlike Taylor (1993) and Rosenbaum (1981) I had no fear or trepidation about the women I was about to interview. I assumed that they would be no different in terms of risk than any other women I knew, and this turned out to be true.

However, I certainly thought deeply about how the interview process and the final research project might affect the women involved. As previously mentioned, the consent form utilized listed the perceived risks of participating in the research project. The women were guaranteed that there would be no risk of arrest, and that all interviews would be confidential and anonymous. My greatest concern was that my questions might elicit painful memories or experiences for the women interviewed. I explained to each woman interviewed that she did not have to respond to any question she didn’t want to answer, and that she should discuss only what she was comfortable revealing. The focus of the research was to elicit the women’s opinions, not to reveal intimate aspects of their life that they might wish to keep private. I knew that opinions are often supported by the revelation of personal experiences, and most of the women did speak about such experiences. Nevertheless, the question format allowed them to choose whether they wanted to include more personal information about their lives in support of their opinions,
rather than asking them directly to supply personal information.

The pilot interviews brought up painful and joyful memories both for the women interviewed and for me. I was concerned that the women I ended up interviewing should be aware of this dynamic prior to the interviews, and that they have someone available to call or visit later if they needed emotional support. As one woman said after I outlined the questions we would cover during the interviews, "It's all painful; all of it's painful" [Tape 31]. I also left a number at which the women could contact me if they felt they needed additional support. In retrospect, the women interviewed appeared to suffer no emotional trauma after the interviews. However, I believe the precautions taken were well worth the time they took.

My background as a counsellor also shaped the interview process. I was used to sitting quietly and listening for long lengths of time and I was sensitive to the range of responses that the questions might produce. However, I could never have anticipated the rich and articulate way the women responded to each question during the interviews. My belief that the women would "say it better" than I could was confirmed in every interview, for each woman had her own unique perception that both broadened the discussion and lent it new meaning.

The Interviews
I must admit that my research process was not as smooth as I would have liked. I was not a polished researcher and at times felt more problematic than some of the women I was trying to interview. Just carrying my infant, my bag, my tape recorder and the food I brought to eat during the interviews often made getting out of the car almost impossible, never mind navigating to the correct apartment or house.

For the first 14 interviews my infant son accompanied me. I had two reasons for bringing him. First, I could not afford the price of a babysitter. Secondly, I wanted to have him play with and entertain the child or children of the woman I was interviewing. Bringing my son worked well until it was time to transcribe the tapes. After transcribing a few tapes it became evident that I would literally go mad if I had to listen to one more child's scream, whether a hurt or joyful scream, over and over and over again. After that discovery, I found the money to secure daycare for him.

The interviews took place from May 1993 to June 1994. As mentioned above, I contacted several women and then set off to do the first two pilot interviews, which were included in the 28. These interviews were quite long and barely directed. I had several questions I wanted to include, but I was not sure at that point how I wanted to conduct the interview. After completion of two of the pilot interviews it became apparent that I could ask several questions that would organize the interview into a format for the rest of the study. I developed
12 open-ended questions, and later added one more, which meant that I had to contact some of the women again to include their responses. I found it interesting that I had not originally included a question that would address the positive side of illicit drug use. This omission was significant in relation to how easily the research question shapes and informs the research results.

The snowball sample worked quite effectively. Through my original contacts I was able to reach many other women outside of the drug-using community that I was familiar with. As well, in the fall of 1992 I visited the public health nurses at East Health Unit and Crab Tree Corner in Vancouver. Public health nurses are often in contact with women whose children have been labelled NAS, and Crab Tree Corner is a drop-in daycare and resource centre that has been active in community education about FAS/NAS. I visited both agencies to describe my research and to hand out one-page information sheets on it. I included a phone number at which to contact me if any of their clients were interested in doing an interview (see Appendix C). However, I did not receive any calls. As I had suspected, unless the women talked to me directly or were contacted through a friend or participant, there was no interest in participation. Fortunately, the snowball sample broadened on its own and I made no further attempts to reach women other than by word of mouth. However, I realized how handicapped social science researchers are in the absence of
historical contact with the individuals they wish to study. This may partially explain why the majority of research on illicit drug users has been conducted through drug treatment centres and prisons.

The majority of the women interviewed were quite settled, and arranging the interviews was easy. A small percentage of the interviews were problematic to set up, though I was surprised how quickly women arranged to meet for the interview, and I had several calls from women wondering why I had not contacted them yet.

One interview clearly depicts the potential unpredictability of arranging interview times. Twice in a row I set up a time for the interview and the participant later cancelled it. A third interview time was scheduled and I arrived at her home to discover that her boyfriend had been arrested the night before and she had been unable to locate him. Rather than conduct the interview, I sat down and started phoning around to help her figure out where he was being held. It is both amazing and discouraging to discover how much more quickly professionals respond to another professional than they do to anonymous woman in need of information. Making the phone calls and talking with the participant took over an hour, so we decided to reschedule the interview yet again.

I was beginning to question whether this woman truly wanted to do the interview. Three attempts seemed enough. I had made a policy, prior to the interviewing, that I would not
aggressively pursue interviews. I would explain that I was only interested in doing an interview if the woman herself was interested. I assumed that this woman was not interested. One week later, she called me early in the morning to ask me when I was coming to do the interview -- as if I was the one who had been cancelling all along. Being a good researcher, I replied, "How about now?" She agreed.

I awakened my child and off we went to her home, a huge apartment complex in a seedy section of town. I got out of my car and went to the passenger side for my child and realized that he was not only locked in the car, but fastened into his childproof carseat. My keys were in my bag, which was also in the car. So were the woman's phone and apartment number. I left my child and ran to the front of the building, hoping that I had remembered the proper apartment number, for this was not the kind of apartment building that listed the names of residents. I had not remembered correctly. I buzzed the caretaker, who was not in. I knocked on a few ground floor apartment windows hoping I could use a phone; people were very nice, but no one had a phone. Finally, after returning to the apartment door and buzzing many numbers, I located the woman I was to interview. She phoned my oldest child to bring the extra set of keys, and later joined me, with her children, and we waited on the street for the spare keys to arrive. By now we were accompanied by several residents and curious onlookers who were calling out suggestions for breaking into the car.
Unbelievably, none of the attempts worked. My son was only two at the time and it was a hot summer day. In desperation, and fearful that he might suffocate from the heat, I was about to break the window when the spare key arrived. After checking that my son was all right and reassuring the crowd, I grabbed my bags and tape recorder and we went upstairs to conduct the interview.

As previously mentioned, I also visited programs for women and children in England, Scotland and the Netherlands for three weeks. I conducted interviews and observed a number of services available to women and children. The interviews and fieldwork were the end result of many years of reading and correspondence regarding services available to women who used illicit drugs and their children in these areas. This research appeared to contradict policy and research results in the United States and Canada. I was curious to see these services first hand, especially after meeting Dr. Mary Hepburn, from Glasgow, when she visited DAMS in Vancouver, and Catherine Siney, a midwife from Liverpool, at a conference in Vancouver in 1993. Both of these women were providing services, and demonstrating pregnancy outcomes that were very different from those found in North American. After corresponding with them and other professionals in the field I decided to visit in September 1993.

At the many services I visited I spoke with women and men who used illicit drugs. I visited areas of visible illicit
drug use. I observed services and spoke at length with many other professionals in the field. I was attempting to understand how they had established services that reflected the needs of the drug using population better than those in North America. Years of familiarizing myself with research and articles describing services in England, Scotland and the Netherlands did not prepare me for the differences I discovered. Although these services were not problem free, they tended to be nonjudgemental, practical, and responsive to the needs of the drug user.

Coding

After completing transcription of the interviews in June 1994, I began the process of coding, using "grounded theory." This entailed several months of reading and rereading the interviews and noting similarities and differences in responses to the questions in the asked. I discovered many patterns and was subsequently able to develop a coding schedule. As in any social science research that includes open-ended questions, a wealth of information was gathered that was not directly related to the questions asked, but completely relevant to the research study. After transcribing the taped interviews onto my computer, I opened separate files for each of the 13 questions in the study. I then analyzed and coded the participant’s responses. I also discovered content themes, which I incorporated into the final analysis of the data.
VI. VALIDITY

In appreciation of the women's trust and willingness to help with this project, I am making copies of the thesis available to all the participants. Several of them have already read different sections, and some have read the whole thesis. Their collective insights and critiques assured me that I have not strayed from my original intent: to create a forum for the women interviewed and to provide a feminist analysis of drug use, mothering and reproductive autonomy within a historical context.
CHAPTER 6 - The Data: Drugs and Mothering

Recently there has been an increase in the regulation of mothers who use illicit drugs by the medical, legal and social service professions. In the past, most research on illicit drug use concentrated on the male user (Addiction Research Foundation, 1994; Bepko, 1991; Ettorre, 1992; Kasl, 1992; Maher, 1995, Reed, 1987; Taylor, 1993, Rosenbaum, 1981). Consequently, it was difficult to discuss how female use of illicit drugs may have differed from male use. This chapter, and the following ones, will introduce the data bringing forward the views of women who use illicit drugs and will demonstrate how these findings relate to the work of other researchers. The following sections include biographical information and examine illicit drug use, stigmatization, pregnancy and mothering.

A biographical profile

The 28 women interviewed represent a wide range of life experience and biographical information. Eighty-six percent (24) of the women lived in the Lower Mainland of B.C., and 14 percent (4) lived in the prairie provinces. The women ranged in age from 20 to 51; the mean age was 35. Of the 28 women interviewed, 32 percent were women of colour -- of these 25 percent (7) were First Nation, and 7 percent (2) were African American. Thirty-six percent (10) of the women were not high school graduates; 25 percent (7) had a high school or GED degree, 18 percent (5) had two to three years of university or
college, 11 percent (3) had a B.A., and 11 percent (3) had a M.A. Twenty-nine percent (8) of the women were employed full time, 71 percent (20) were on welfare. Of the later, 18 percent (5) were either attending university or college courses full-time or participating in full-time volunteer work (see Table 6-1).

All of the women had used either narcotics or cocaine derivatives (or both) in a dependent or addictive manner, although their drug use was not static (see Table 6-3). The length of drug use varied. The mean average was 14 years, but the range of use varied from two years to 34 years. Many of the women had ceased using drugs altogether at the time of the interview, and others had ceased use for periods of time up to five years before using again.

Only 18 percent (5) of the biological fathers lived with the women and children in the home. Seventy-five percent (21) of the women fully supported their children without financial assistance from the children's father. Sixty-eight percent (19) of the women remained single parents. Twenty-five percent (7) had steady partners (who were not the biological fathers of their children) or were married (see Table 6-1). Eighteen percent (5) stated that they were in new relationships that were not permanent.

In all, there were 59 children. Of these, 14 had been labelled NAS, and ten of the 14 had been treated at the Sunny Hill in-patient program and 7 of these ten infants were
permanently apprehended by the Ministry of Social Services (see Table 6-2). In total, thirty-six percent (21) of the children were no longer in their mothers’ custody, although more than half of these were in the custody of relatives, or ex-husbands (see Table 6-2).

Table 6-1
Demographic Characteristics of Interviewees

<table>
<thead>
<tr>
<th>Total Sample: 28</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-25 years</td>
<td>6</td>
<td>21.</td>
</tr>
<tr>
<td>26-30 years</td>
<td>4</td>
<td>14.</td>
</tr>
<tr>
<td>31-35 years</td>
<td>1</td>
<td>3.</td>
</tr>
<tr>
<td>36-40 years</td>
<td>8</td>
<td>28.</td>
</tr>
<tr>
<td>41-45 years</td>
<td>5</td>
<td>18.</td>
</tr>
<tr>
<td>46-50 years</td>
<td>2</td>
<td>7.</td>
</tr>
<tr>
<td>51 + years</td>
<td>2</td>
<td>7.</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>19</td>
<td>68.</td>
</tr>
<tr>
<td>married/common law</td>
<td>7</td>
<td>25.</td>
</tr>
<tr>
<td>widowed</td>
<td>2</td>
<td>7.</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>European Heritage</td>
<td>19</td>
<td>68.</td>
</tr>
<tr>
<td>African American</td>
<td>2</td>
<td>7.</td>
</tr>
<tr>
<td>First Nation</td>
<td>7</td>
<td>25.</td>
</tr>
<tr>
<td><strong>Education Completed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 9-11</td>
<td>10</td>
<td>36.</td>
</tr>
<tr>
<td>Grade 12-13</td>
<td>7</td>
<td>25.</td>
</tr>
<tr>
<td>Community college/Some university</td>
<td>5</td>
<td>18.</td>
</tr>
<tr>
<td>University Degree</td>
<td>3</td>
<td>11.</td>
</tr>
<tr>
<td>Graduate Degree (MA)</td>
<td>3</td>
<td>11.</td>
</tr>
<tr>
<td><strong>Socioeconomic Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professions/Managers</td>
<td>6</td>
<td>21.</td>
</tr>
<tr>
<td>Self employed/middle management</td>
<td>2</td>
<td>7.</td>
</tr>
<tr>
<td>Full-time student/volunteer with some welfare assistance</td>
<td>5</td>
<td>18.</td>
</tr>
<tr>
<td>Welfare assistance</td>
<td>15</td>
<td>53.</td>
</tr>
</tbody>
</table>

221
Table 6-2
Children of Interviewees

<table>
<thead>
<tr>
<th>Total Sample: 59</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently in mother’s custody</td>
<td>38</td>
<td>64.</td>
</tr>
<tr>
<td>No longer in mother’s custody</td>
<td>21</td>
<td>36.</td>
</tr>
<tr>
<td>In permanent care of relatives</td>
<td>12</td>
<td>20.</td>
</tr>
<tr>
<td>In permanent care of Ministry of Social Service</td>
<td>9</td>
<td>15.</td>
</tr>
<tr>
<td>Children Labelled NAS (all infant’s mothers on social assistance)</td>
<td>14</td>
<td>24.</td>
</tr>
<tr>
<td>Infants labelled NAS currently in mother’s custody</td>
<td>6</td>
<td>43.</td>
</tr>
<tr>
<td>In-patient NAS (Sunny Hill) infants</td>
<td>10</td>
<td>17.</td>
</tr>
<tr>
<td>In permanent care of Ministry of Social Services</td>
<td>8</td>
<td>13.</td>
</tr>
<tr>
<td>Total children in care at some point due to permanent and temporary child apprehension, relinquishing custody to relatives or NAS in-patient care</td>
<td>32</td>
<td>54.</td>
</tr>
</tbody>
</table>

I. WOMEN’S PERCEPTION OF ILlicit DRUG USE

Women who use illicit drugs are subject to arrest because the possession of "narcotics" is a criminal offence in Canada. The data suggest that although many drug users in Canada are polydrug users, most have a drug of choice. Individuals who consume drugs have varied reasons for doing so, and people can have different experiences with similar drugs (Alexander, 1990; O’Hare, 1992; Peele & Brodsky, 1991; Weil & Rosen, 1993). For example, some people prefer heroin; others prefer cocaine. For women who use illicit drugs such as heroin and
cocaine, the secrecy, social stigma and lifestyle involved can be problematic. Social attitudes regarding illicit drug use, especially in relation to mothering, are quite negative and have significant consequences for women (Maher, 1992, 1995; Humphries et al., 1992; Rosenbaum, 1981; Rosenbaum et al., 1990; Taylor, 1993).

Researchers have noted that women's experience of illicit drugs use is often positive (Henderson, 1993a, 1993b, Rosenbaum, 1991; Taylor, 1993). The majority of the women interviewed stated that their experience of their drug use had been positive, especially when they initially began to experiment with illicit drug use. Furthermore, even the women who experienced problematic and negative addiction agreed that there were positive elements to their illicit drug use. In fact, when I asked if there had been anything positive about their drug use, they often laughed, exclaiming, "Of course!" [Hope] and "Oh, absolutely!" [Donna].

There seemed to be agreement among the women interviewed that illicit drug use was educational and fun. The following quotation captures the general response of the women interviewed to the question "Has there been anything positive about your drug use?"

Initially it was exciting and fun, even educational.[Carol]

Another woman noted that her drug use was fun and taught her to be a survivor:
It was fun. I really had a lot of fun in the beginning. And it taught me [that] I’m a real survivor, and a real go-getter. I’m amazed myself with the amount of money and drugs that I could come up with.[Bobbi]

A third woman explained how she would not have met all of her close friends if she had not started using illicit drugs:

Of course it was fun! I wouldn’t have met all of you guys if I hadn’t used.[Sarah]

One mother described the lifestyle, and her wish to live outside of the mainstream:

I loved the separate aspect of the lifestyle - sleep all day, party all night, not working but having lots of money. For example, we paid cash for a new car, took trips, etc. I had come from a poor family so I feel this played a part. I wanted to be different, out of the mainstream. I see all aspects of my life as positive as they are simply part of the process of my journey.[Carol]

Drug use, especially addiction, can be painful (Rosenbaum, 1981); however, the women interviewed described how even though they had experienced pain due to their addiction to illicit drugs, there were positive outcomes subsequent to their drug use. One woman describes how she learned more about herself by examining her negative addiction:

But as far as positive....I guess I learned about compassion for people who are on drugs or alcohol. Or even have emotional hangups. Because I learned that my addiction [is] a symptom of my pain. Maybe I would never have learned that without the problems that I had.[Bobbi]

Another woman noted that her addiction to illicit drugs had enabled her to stay sane in the face of abuse:

I really froze after my mother died. And that was probably when my problems started, and it wasn’t the drugs. The drugs were a vent. And when I was
abused it was more of a vent. And I probably would have gone crazy if I hadn't been running away to freedom....The drugs really kept my brain intact, and it probably kept me going through a lot of stuff; it just sort of blotted out reality for enough time so I could pick myself up again. And it really had to be [to] the point where I didn't need to blot reality out [before] I could stop. If I had stopped before then I would have just started the next time I needed it. [Donna]

For the women interviewed, drugs and drug use meant different things. However, all agreed that aspects of their illicit drug use were positive. Traditional drug research has ignored the positive aspects of drug use (Hadaway, Beyerstein, & Youdau, 1991; Henderson, 1993a, 1993b). Depicting female drug users solely as victims who lack agency is faulty (Henderson, 1993a, 1993b; Maher, 1995; Taylor, 1993). It is clear that women who use illicit drugs do so because they wish to. Similarly, describing female drug users solely as using drugs to cope with the stresses of their life is faulty (Maher, 1995). The women interviewed in this study and in Taylor’s (1993), and Maher’s (1995) study did not conform to the prevailing stereotype of women illicit drug users as passive victims. There is a wide range of responses to illicit drug use.

The Drug of Choice?

Of the women interviewed for this study, 3 percent used Ts & Rs (talwin and ritalin), 43 percent considered themselves to be narcotic users (users of opiate derivatives), 39 percent were cocaine users and 14 percent used narcotics and cocaine equally (see Table 6-3). At the time of the interview, 25 percent of the women were taking legal methadone (see Table 9-
Thirty-six percent had been on legal methadone in the past.

Table 6-3

<table>
<thead>
<tr>
<th>Drug of Choice</th>
<th>mean duration of use: 14 years</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Sample: 28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opiate derivatives</td>
<td></td>
<td>12</td>
<td>43.</td>
</tr>
<tr>
<td>Cocaine derivatives</td>
<td></td>
<td>11</td>
<td>39.</td>
</tr>
<tr>
<td>Both cocaine and opiates</td>
<td></td>
<td>4</td>
<td>14.</td>
</tr>
<tr>
<td>Talwin &amp; Ritalin</td>
<td></td>
<td>1</td>
<td>3.</td>
</tr>
</tbody>
</table>

All of the women interviewed had strong opinions about their drugs of choice and their preference for regular use. All had experimented with both stimulants and depressants and with polydrug use. In contrast with the disease models of addiction, it was clear that their experiences differed in terms of both physiological effects of the drugs and patterns of use. For example, the women described the different effects they experienced when using heroin and cocaine:

Coke, yes. I think that is the devil's drug. It makes you run out...in the street and do stupid shit for it, unlike heroin. I mean, I used heroin for many years and I never did as many stupid things to get it as I did for coke. But I think that partially that is the nature of the drug, too. You know, you are down and out and you are pretty unaware of things going on around you and so you don't participate in them. So, in itself it keeps you safe. With heroin, at least it [lasts] six or seven hours, if it is real good. When [using cocaine] you are driven out on the street every 20 minutes.[Pat]

I think they tend to lump every drug together, too. You know, the effects of cocaine and heroin are very different. Almost total opposites, I would think.[Diane]
The route of administration, type of drug, duration of effect, and cost, mediates a person's drug use. So do class, race, gender and drug legislation. The effects of heroin generally last from four to six hours, the effects of cocaine from 20 to 45 minutes. Therefore the type of drug used, as well as drug legislation, may mediate how the drug is experienced by the user. Not all of the women perceived cocaine as the "devil's drug." Rather, many who were cocaine users described their drug use in terms of their own subjective experiences and often in terms of their rejection of opiate derivatives:

Well, I never really liked junk anyway. I always got sick. I liked the go fast drugs. But, I love the cocaine. [Sarah]

I don't like heroin. I'm not a downer. I like the rush of cocaine. I'm a speed freak. [Janet]

I haq been addicted to heroin when I was 16....I got off it...I thought oh god, I never want to go through that again. And then I was introduced to cocaine....I think I liked that awake high much better than that sleepy [one]....It was fun, you talked a lot. It was energy. I liked the energy. [Bobbi]

I even tried heroin....But I didn't like the high, I didn't like sleeping...I didn't want to be down, I wanted to be up. So cocaine was the thing. [Ellie]

The women who preferred cocaine to heroin use were attracted to its stimulating effects. In addition, one young woman noted that she felt her drug use was more in control with cocaine than with heroin:

When you are on heroin you get sick. You have to do it. And I didn't like that idea of, you know, the
drug was controlling me, and I didn’t want to be under that much control. [Karen]

Obviously, heroin and cocaine are not as compelling as once thought. The women in this study tried many different drugs without becoming addicted to them. It is evident that many individuals experiment with heroin and cocaine use without becoming long-term users (Blackwell, 1983; Cheung et al., 1991; Erickson, et al., 1987; Matthews et al., 1995; Waldorf et al., 1991).

In contrast to the women who preferred cocaine or other stimulants, many of the women who preferred heroin described cocaine use in negative terms. Two women from working-class backgrounds stated:

I never did like cocaine all that much, though I did it because it was there....But it was not my drug of choice ever and I was always really afraid of the come down. [I] hated the whole scene, it was such a mess. People would o.d.\textsuperscript{18}, and all those needles, and all the blood, yuk; and all those misses...oh god. [Gloria]

I did every drug...the only drug I never did was crack....I could have done crack too, but somewhere I heard that they use...some kind of cleaning thing to do it, and I thought I’m not doing that....I wouldn’t do it, I thought of it as bad for my health [laughter]. [Morgan]

The fact that cocaine needs to be injected or sniffed more often than heroin, due to the short duration of its effect changes the environment of use for many women, especially intravenous (IV) users. For the majority of women, their drug of choice depended on assessment of risk and whether they

\textsuperscript{18}overdose
preferred a stimulant effect, or a depressant effect. However, many who preferred depressants noticed that once they became addicted to heroin, it began to have an energizing effect. For example, one professional woman described how she cleaned house after using heroin:

Instead of doing what they're meant to do, they do the opposite. So I know there's metabolic changes going on or whatever [laughter]... it was wonderful to be high to do housework. I would have all this energy. Well, you are supposed to be on the nod. I mean when you are first using, sure you nod out. I couldn't move or I would throw up. I don't know why I continued doing it. But the thing is, when you do it often you do it for energy.[Gloria]

While using heroin, household chores became more bearable, and regular use altered the effects of heroin. As noted above, many of the women noted that heroin was their preferred drug:

I got into heroin so quick, actually...before anything else. I just left everything else. Then it was just heroin.[Evelyn]

Heroin or opium is my drug of choice, but smoking it now.[Hope]

I was more like a chippy, I mean I chipped every day. [Sarah]

I loved opiates right from the beginning, and recognized that I could get opiates in other forms, other than opium and smoking it. So I was able to start figuring out how to do codeine, how to do pills everyday, that kind of stuff.[Debbie]

All of the women were self-educated about the numerous legal drugs they could consume. The wide array of pharmaceutical drugs available contributed to their polydrug use, especially when heroin was scarce and expensive. Some of the women whose drug of choice was heroin used methadone, legal narcotics and
heroin interchangeably according to availability. The use of licit drugs were very much a part of the women’s overall drug consumption.

Many of the women discussed their own use, and the use of their family of origin’s, of legal drugs. Tobacco, alcohol and pharmaceutical drugs formed a backdrop to their discussion of illicit drug use. However, the fact that many illicit drug users are polydrug users does not mean that all drugs are interchangeable, or wanted. One woman who has been on legal methadone for over 15 years noted:

I never did a Valium. In fact I rarely even did aspirin. [Evelyn]

Other women noted:

I know that my drug of choice is not coffee, because I’m different from most people because I don’t like coffee. And I get high from coffee, and it’s not pleasant. [Morgan]

I don’t like methadone personally. I felt like this is the only drug that they would allow to be legal. [Hope]

If I had a choice of how I wanted to get high it wouldn’t be a beer. [Morgan]

This is my one habit [cigarettes] that I allow myself to keep without guilt....I mean I shouldn’t have to, but I do. I know it is a big thing....It is really way worse than any drug that I quit. [Mary]

One upper-middle class woman explained:

When I was growing up, girls from our side of the tracks did not drink. We never drank. [Janet]

All of the women had formed opinions about specific drugs, and in practice avoided many drugs. Although some of the women had
difficulty in relation to alcohol use, many of the older women rejected alcohol, perceiving it as the drug of choice of their parents:

So all of that generation smoked cigarettes and drank heavily and the following generation, which was my generation, we were all heavy [drug] users. [Debbie]

Still, many of the women recognized that even though they had chosen illicit drugs, they were following the same path as their parents in terms of their dependent use of a drug. One woman from a middle-class background stated:

Alcohol has never been a problem...But I was raised by a severely alcoholic family, and we never wanted to have anything to do [with alcohol]. I kept fighting. I am not going to be like my mother. I am not going to be like my mother. But I am. [Pat]

However, the legal availability of alcohol makes it significantly different from heroin and cocaine. Whereas, it is socially unacceptable for women to drink heavily in North America (Sandmaier, 1980), the criminalization of women who use illicit drugs involves much heavier penalties.

Social Attitudes and Social Stigma

During the interviews many of the women described prevalent social attitudes concerning illicit drug use. Misconceptions and stereotypes were discussed, as well as the consequences of misinformation regarding illicit drug use. One prevalent myth equates all illicit drug use with highly visible street use. Many of the women described how this misconception affected them.
One worker says, well, did you ever go downtown? Everyone associated downtown....I guess you can call us...suburban junkies. [Evelyn]

People think that addicts are easily identifiable or maybe they don’t, I don’t know. But there seems to be a consensus [that] they are only on the street; that’s just not true. When I went to the treatment centre there were 60-year-old women kicking Valium addiction, narcotics addictions for painkillers that they had for arthritis, or whatever, you know. Whatever it started out to be, they got wired out on the pain killer. And they are getting them, not for killing the pain of arthritis but because they were sick without them. [Gloria]

Where a person consumes her drug and how she obtains it depends on her socio-economic status and on drug legislation. Middle-and upper-class users do not have to buy on the street; rather they are able to obtain illicit drugs in their own neighbourhoods:

It wasn’t hard to find. It was like every neighbourhood had the neighbourhood house dealer....I was never downtown....Never had to. [Evelyn]

In addition, the social fiction separating illicit drug users from users of prescribed legal pharmaceuticals was apparent to the women interviewed. Alexander (1990) notes how negative labels reserved for illicit drug users have emerged in North America. All of the women, regardless of socio-economic status, were aware of the negative stereotyping of illicit drug users in Canada. Stereotypes made it difficult for many

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19Throughout this thesis I refer to "middle- and upper-class" users and "poor" users. "Poor users" refers to women who are visible illicit drug users on social assistance. "Middle- and upper-class users" refers to women who work or go to school.
of the women to reveal their illicit drug use to others and sometimes even to come to terms with their own illicit drug use. The women stated that most illicit drug users were perceived as "addicts" rather than as individual women who use illicit drugs, and their humanity was obscured:

It's like the war on drugs has made a monster out of this. And they are not willing to look at people as individuals and as human beings with problems and with circumstances in their lives that are even external to the drug use. [Carol]

Yeah, you are not a person, you are just an alcoholic or you are a drug user. [Cindy]

You know, in many ways drug addicts are extremely good scapegoats for North Americans. I mean we don't have scapegoats, we can't use religion now. We can't use colour now. What is there left?... So we use drug users and street people. [Theresa]

Maybe some people have this thing inside where they have to feel better than you. I don't know, I've heard people say that. And especially in the white, dominant society... Is it true that these people want to oppress another group? Or have a need to do that?... I don't think that that's a natural feeling, but I think that's what's happening. And I classify drug addicts right in there with other oppressed groups: women, people of colour, even handicapped people. [Morgan]

Alexander (1990) states that the "the war on drugs" fits the same pattern of wars of persecution. The connection between social attitudes and personal use of illicit drugs was relevant to the women interviewed. They were conscious of the larger social, political, and economic variables that not only shaped their personal drug use, but contributed to their oppression and to that of other groups outside the dominant
white culture. The women questioned the prevailing environment that perpetuated oppression. One professional woman stated:

You know, sometimes I wake up, hear something on the news and I wonder what kind of society is this? What have we created? It’s so horrific, it’s so twisted. The other night some hockey team won and cars were beeping and people shouting for over an hour. All that passion for a hockey game. But try to interest people in changing society - looking at war, for instance. Even the peace march was cancelled this year for lack of participation. Now what kind or society is that? I really don’t understand how people...can be so ignorant, so blind. Why don’t they get it that this whole segment of society is being trashed? They think they’re outside of it. But this attitude of wanting to judge, control and hurt drug users is sick. You can’t turn on the T.V., or watch a movie, without seeing some drug dealer blown away. Even in books there’s all these references to "drug addicts." What’s so frightening to me is these references assume that it is something criminal, deviant, evil, less than. These aren’t people any more, they don’t even have names, just "dealer" or "addict" and we are all supposed to know what that means. Well, I don’t. There is a person under all that. [Hope]

The social, political and economic environment shapes illicit drug use. Furthermore, the limiting and oppressive structure of society can often become glaringly apparent when one’s behaviour is criminalized.

Just as traditional drug literature presents a prevalence of negative (as opposed to positive) motivations for illicit drug use, negative stereotypes regarding illicit drug users prevail among the public. Yet, most of the women interviewed described other users in positive terms. Often it was a person or group of people, rather than the drugs themselves, that
brought women to associate with other individuals who used illicit drugs. For example, several women noted that:

Yeah, the people I liked were doing drugs, although they were doing soft drugs. [Gloria]

Even when I first starting using drugs, for the first time, illegal drugs, the people who I did them with were great; they were nice people. [Morgan]

I think addicts are the most loving, caring people that you could ever meet. [Sarah]

We got support amongst the other addicts. I mean we became good friends...not because we are just addicts together, but we had something more in common. You know...we like what we are doing but, you know, the lifestyle that goes with it, is what we didn't like.... But, other than that, I ended up with the best friends.... Yes. I still see them. You know, to this day they are still supportive.... You know, even though our lives have gone different directions, all of us. But...our friends were our support. That is when true friendship really came about...they say a junkie doesn't have friends. That is not true. [Evelyn]

And of course it turned out that these were just normal people and I liked them and I thought, well, I feel fine here. This can't be so terrible. And I don't regret that. [Linda]

For many of the women, the stereotype of the deviant addict was quickly abandoned once they met illicit drug users. Similar to other studies of female drug users (Rosenbaum, 1981; Taylor, 1993), in place of stereotypical negative characteristics, they found lasting friendship and support. They recognized the thin line separating users and non-users:

You [society] think that you are so much different than I am, that I am a breed apart, but I am the same person you are. And I have been on your side and I have been on my side. And I know how easy it is to jump from one to the other, and how easy it could happen to you. [Pat]
However, women crossed the line separating licit and illicit drug use, the illegal status of their drug of choice had significant ramifications, especially in terms of lifestyle. **Lifestyle**

The life of an illicit drug user can be very difficult, especially if she is poor. Besides her fear of arrest and child apprehension, there is the constant need of money to buy drugs on the illegal market. Many of the women, both low-income and middle-class, discussed the lifestyle that often accompanies the use of criminalized drugs:

> I really hope people don’t choose this path. I wouldn’t wish it on anybody, you know....It’s just too hard. It’s always a problem. [Gloria]

> It has affected my life very detrimentally by having to see certain people that I would not necessarily see, because of course that has been part of my life....who has got, and who has got stolen stuff...you know, the whole criminal stuff. [I’m] subjected to [that] constantly. [Judy]

> Yeah, it is mostly the bizarre nature of the lifestyle...I couldn’t live with it any more. It was making me crazy. [Pat]

The criminalization of drugs contributes to the illegal market that women must negotiate in order to buy illicit drugs. In this environment they often have limited choices in who they buy their drugs from. As well, although they may be able to maintain a fairly stable environment within their homes, negotiating to buy and sell drugs has often brought the women in contact with other criminal activity and police surveillance (Taylor, 1993). However, the majority of women were adamant that it was not their illicit drug use that was
wrong, but social attitudes and poverty that contributed to an 
unpredictable lifestyle:

Give me a break. I mean, you take something as 
innocuous as drugs and turn around and say "oh, 
this is terrible," when it is society that makes 
the life terrible. Not the drugs 
themselves.[Theresa]

Other women noted that financial status strongly affected 
their experiences as illicit drug users. One professional 
woman from a working class background stated:

Even when you are using, that's not all you're 
doing. You still have a life, relationships, goal... 
The poorer you are the more time it takes to get 
money to score. But if you have money, or the 
drugs, it doesn't take that much time to use. So 
you are just living your life the rest of the 
time.[Hope]

Another professional woman noted:

At that time, because of the success of my drug 
dealing...I was able to easily get money, easily 
keep myself in supply.[Debbie]

And one mother who had been a full-time university student 
noted:

I didn't lead a life where I had to do terrible 
things...I was never really hungry and I never had 
to be a prostitute unless I felt like it. You know, 
I was sick a few times but generally I had drugs 
and had money and as a matter of fact, I was way 
better off financially than I have been since I've 
gone to school.[Theresa]

Illicit drug use is just one variable in a woman's life. 
The time and energy devoted to obtaining drugs is determined 
in part by one's class. Street use usually involves daily 
buying and selling of drugs, often several times a day, as one 
earns the money through legal and illegal activities. Other:
less visible use is shaped by the larger quantities of drugs available. Many middle- and upper-class users in this study were able to buy and sell large quantities of drugs. Such women did not have to devote time and energy to the daily acquisition of their drugs of choice the way a street user would have to. Therefore, the pattern of use shifts according to availability and economic status.

Prominent themes running through the interviews included the lack of legitimacy, silencing, and social stigma attached to illicit drug use. The term "social stigma" refers to negative labels "affixed to the social image of individuals or groups, and which...serve as a means of social control" (Shoham & Hoffman, 1991, p. 106). The social stigma attached to illicit drug use was described by low-income, middle-class and professional women:

Just the misinformation that goes out about drugs and drug use to the public...people form their immediate opinion of any one that's used drugs...I think that's been the worst thing for me, that stigma. That I've managed to repress myself as an adult because of things I did years ago.... low self esteem all of that. Basically what it did for me, the laws have attached a stigma to drug use....And that's really hard to get over...if you ever do get over it.[Morgan]

Heroin...[there's] so much of a social stigma on it.[Linda]

Another myth that really irritates me is the one [that] every junkie is out selling to the kids in the street and the schools. I mean, it is just not true. Yes, there are some really sleazy people. Probably in...larger urban centres where there is a lot more access to drugs. Like maybe in Vancouver. [But] I don't think that is happening. When I lived in Vancouver, I never saw it....the police love to
have everybody think that is true, because that makes everybody hate us. I mean, we are the drugs of the earth. Definitely....who is worse than a junkie, nobody. And who is worse than a junkie mother? I mean that is the ultimate put down, right?...all it is to me, is just the ultimate in sadness.[Carol]

The worst thing you can be in this society is a drug addict or a drug pusher. I think it is a harder thing to overcome than being a murderer. When you look at sentences, people who traffic drugs...I am talking about people who traffic, who are addicts and who are trafficking to keep themselves going. They end up with more time than people who molest children....And they did more time, a greater percentage of their sentence than people who do other things. Now, I think that...this society has done a really good job of misleading the public...laying out all kinds of misinformation....I think that our society has to get real about it...even if they do decriminalize it, well they won’t decriminalize it unless some of these things and attitudes get changed....Basically, they are making it impossible for a lot of people to ever get beyond this. I think that they think that people [who] become addicted are weak and stupid....I think that a lot of people end up believing that they are. Even if you are really strong...sometimes, it is just really hard to get out and to get beyond this.[Diane]

We ourselves are not bad people and we have to look at that first. Because when they treat you like shit, then you react like shit. You know, if you treat me a certain way, then I am going to react to that. But, I also don’t think that drug users need sympathy all the time. We just need to be treated like human beings.[Sarah]

The social stigma surrounding illicit drug use takes a personal toll on women (Ettorre, 1992; Rosenbaum, 1981; Rosenbaum et al., 1990; Taylor, 1993), for the negative images are difficult to challenge in one’s private and public life whether a visible or nonvisible illicit drug user. The barrage of negative images reinforces both stereotypes and harsh drug
policy and legislation. All of this contributes to an environment of dehumanizing behaviour toward illicit drug users.

Silencing and lack of legitimacy

All personal use of illicit drugs eventually intersects with social attitudes surrounding drug use. Even nonvisible users interviewed were affected by the negative images of illicit drug users portrayed by the media and government. Often negative messages were internalized by the women, which hindered their own stabilization and recovery. Two women from working class backgrounds conclude:

I think it's how we view people, and that's the way that I carry it. I think it's what we believe...if...people on the street think that they are doing a terrible thing, then they are....Oh yeah, internalize it and we become repressive to ourselves. And most of the damage I've done is to myself, but with the help of the entire society. But I'm the one who is there with myself and who is repressive.[Morgan]

Even people that are your friends and love you, it's hard for them to understand because we're bombarded by the media and by...the whole attitude, the whole...Christian sort of [attitude] like good/bad...or weak/strong. But even within ourselves we feel that, right. So you can't really blame other people for falling into that pattern of thinking about you.[Gloria]

Trying to maintain a positive identity in relation to illicit drug use can be very difficult in the face of opposition. Furthermore, the secrecy involved in illicit drug use furthers one's sense of alienation from mainstream culture and from one's immediate friends and family. Three professional women note:
Being a drug addict is almost like being a baby-rapist or something. The way people see you....I just hate the secrecy....I hate to have to hide, I really do. But I have to....I think, if only I hadn't taken that path. It closed some paths forever, or it seems to. I don't know if that is true but I feel like there are some doors forever closed to me.[Gloria]

I have always felt that; that is a part of my life that I have been forced to hide. And even throughout my recovery like...I am not comfortable to share that with people, because I know that it will be taken in a negative way. I am afraid of the ramifications. I worked so hard to get where I am that....I think that it would be beneficial, I would love to share my past and have it in a positive light, so that it is a role model for other people....When I was addicted, there was nobody out there that I could say, well, they made it. Because the way that it is all set up is that you only look at the negative things. You only look at the people who are going back to jail. I mean, just turn on the news any night.[Carol]

The stigma and the secrecy is really difficult. At this point in my life I worry that my past will jeopardize my plans for the future....I feel dishonest hiding my past. It feeds into that whole feeling that you are not legitimate and I had enough of that feeling when I was using.[Hope]

Not only did the need for secrecy contribute to a sense of personal dishonesty; it also reinforced the women's sense of lack of legitimacy. Secrecy and silence were essential practices to most drug users due to the illegal status of their drugs of choice. The fear of arrest, social service intervention, social ostracism and limited employment choices fuelled the need to remain silent. Due to the criminalization of drugs, low-income and middle-class and professional women noted that they had no legitimate voice in society:

They never ask anybody's opinion; they just go ahead and do things based on what they think but
they never ask us. Nobody ever asked me what I thought. [Karen]

Indirectly, it makes you feel like some...not a real citizen of the country...You don’t feel legitimate, a legitimate person because you are considered a criminal. [Judy]

It is frustrating. You know, I have all this knowledge and nobody wants to listen....The people who should listen don’t want your input. Your input makes sense. Theirs doesn’t. [Evelyn]

You get treated like an idiot...that doesn’t have a voice. [Pat]

I think I’ve been silenced all my life, through fear, by men, by society. All my life these thoughts circled around inside. No one ever took the time to ask what I thought. All these things that affect you, but no one asked. But I’m still silenced, because I’m not going to inform any public meeting or place that I’m a drug user. Let’s be realistic; it’s illegal to use certain drugs in our society. [Hope]

Few illicit drug users have a legitimate voice in Canada. Unlike other countries, such as the Netherlands where the Junkiebond advocates for illicit drug users, Canada has no central organizing group of illicit drug users and ex-users representing and advocating for themselves. However, groups such as the Concerned Citizens in British Columbia have focused on education, and more recently this focus has been expanded to challenge changes in methadone drug treatment in B.C.

Women have historically had limited participation or voice in political and private life. Criminalized women are even more circumscribed and are rarely offered a legitimate voice in society. The social stigma surrounding, and
criminalization of, illicit drug use have contributed to the silencing of women. Until recently there was little information regarding female illicit drug users. Currently, much of the research on illicit drugs centres on women's failure to mother adequately, and the harm they may inflict on their unborn fetuses (Cain, 1994; Logi, 1990; Shaw, 1985; Steinberg, 1994; William & Bruce, 1994). The combination of mothering and illicit drug use is portrayed as immoral and dangerous. Consequently, women - and especially mothers - are seen as more deviant than their male counterparts, and this stereotype contributes to their silencing.

II. ILLEGAL DRUG USE AND MOTHERING

As discussed earlier in Chapter three, the ideology of mothering in Western countries portrays women as virtuous, caring, giving and pure (Collins, 1994; Glenn, 1994; Gupta, 1995). This ideology obscures the reality of mothers' daily lives. Glenn (1994) explores how women in Western society have full responsibility for family life: they are expected to take care of the household, raise the children, and care for relatives, including husbands. For most women, especially poor women, this means long hours of unpaid and unacknowledged work (Glenn, 1994; Oakley, 1986, 1992). When women are perceived by the legal, medical or social service professions as failing in their role as mothers, they are punished (Chunn, 1995; Gallagher, 1987; Humphries et al., 1992; Maher, 1992; Maier, 1992; Rosenbaum et al., 1990). When women are denied the
chance to mother their own children through separation due to incarceration or child apprehension they are further stigmatized by society through social ostracism and harsh sentencing (Carler, 1976, 1983; Daly, 1987; Eaton, 1983, 1985; Masson, 1992).

Women who use illicit drugs are considered to be unfit mothers, out of control, and a danger to their children (Paltrow, 1992; Rosenbaum et al., 1990; Taylor, 1993). However, a comparable set of characteristics concerning fathers who use illicit drugs is lacking in drug literature. Although most research on illicit drug use centres on the male user, his parenting qualities and responsibility to his family are rarely addressed. Rather the male user has often been described as the "man about town" (Preble & Casey, 1969) and little was known about his family relations until Hanson et al. (1985) studied male heroin users in the United States. Outside of the area of monetary support, little attention has been given to the family responsibilities of male illicit drug users. This reflects Western ideological assumptions about men, as opposed to ideological assumptions concerning women.

In contrast, research on women who use illicit drugs overwhelmingly explores, and often centres on, the women's lack of parenting abilities, and failure to be responsible for children and the household (Chasnoff, 1989; Julien, 1992; Peak & Papa, 1993; Robins & Mills, 1993; Steinberg, 1994). For many women, pregnancy is an event that significantly changes their
status in society (Kitzinger, 1992, Oakley, 1992; Rothman, 1989). Women who are identified as illicit drug users during pregnancy are closely monitored by medical, and social services professionals, who assess, and eventually determine, maternal health and parental fitness.

In the course of the research, it became apparent that the women interviewed perceived themselves as different from male drug users who are parents, because of their role as mothers. The full responsibility of caring for their children shaped their drug use, both positively and negatively. Women in Canadian society are offered little socio-economic support in caring for their families, and when family break-up occurs, the individual mother is blamed rather than society. Caring for children and other family members is difficult, time-consuming work. Many of the women spoke about the sole responsibility of mothering when responding to Question 8 "Has it been different for you being a mother who uses drugs than it would be for a male drug user?" Eighty-nine percent of the women claimed that their role as mothers who used illicit drugs was different from that of male users. The sole responsibility for care and the lack of fathers' participation in the family were evident in their responses:

The whole idea of having a child, to be a mother, to take care of and support that child and love him. I mean all those things that come with the mother category, right. You can't be out there partying and hanging out, and coming home when you want to. Being stable and having a home and cooking meals three times a day, and if you are going to
school or work, well, having a good babysitter. [Ellie]

I do think men don’t have the same kind of...that’s sexist too, but most men are not as committed parents. [Judy]

Oh, the twins’ father was out of control, but he was a user too. He didn’t have any obligations. When I would take off...he would be in my place where I had all my kids. And the first thing he would do is phone his mother. She would come to get the kids, and then half the time he would end up downtown with me because he would know that I would have money, be making money there. He had no obligations, he basically had free rent when he wanted to come and didn’t have to do anything. Being a single male he had nothing stopping him. [Donna]

Most definitely....I guess I felt some kind of responsibility. I am not sure men always feel that responsibility as we do. [Sarah]

I have more responsibilities. A guy can split and do whatever he wants.... A woman can’t. I mean, she can, but there is a bond between your children that just...for me is unbreakable. I could not just get up and leave my kids. I may threaten them with "You know, if you want to...go to a foster home, you are headed in the right direction kid"....You know how kids get at 12....But I mean there is just no way...you are bound with an unbreakable thread...I don’t know how it works. [Theresa]

Probably only for the women involved [laughter]. [Pat]

The only thing that would be different for me doing drugs, was my kids...a man can walk away. A mother has...no other choice, if she has a kid....A woman can...up and leave. But,...who... is going to look after the children?...Then the mother has that guilty conscience of leaving the children behind. [Men] they don’t have a conscience. [Julie]

Women felt responsible for the care of their children. Taylor (1993) notes that few of the women in her study of illicit drug users in Glasgow received help from their male
partners in caring for the family. Similarly, in this study, the biological fathers of the children gave little or no support to the majority of the women in caring for the family. Creating and maintaining a home life, daily structure, food, shelter and emotional and financial support were the sole responsibility of the majority of mothers. The mothers adhered to prevailing ideological assumptions about mothering and strove to maintain homes for their children. Only five of the women interviewed had supportive husbands, though three of these husbands had served lengthy prison sentences due to their status as illicit drug users, which left the mothers coping with the household without their daily support during their incarceration. In fact, the majority of the women’s assessment of men in relation to family responsibility was fairly negative. As one woman of European heritage concludes:

I don’t think that is common to drug abusing people though. I mean....all men do that, find it very easy to abandon their children. To whatever situation that they probably have little or no knowledge about and are fine to just waltz off with that....I think that is the thing that is common to men, whether they are using drugs or drinking or doing anything else. Men are just like that...and women aren’t in general.[Pat]

For this sample of women, the majority of men offered no support and appeared to have little difficulty abandoning their families, leaving the mothers with sole responsibility for the children and household. As will be discussed in Chapter eight, the loss of children to the Ministry of Social
Services, or to relatives, was a primary concern to many of the women interviewed.  

**Pregnancy and Birth**

Taking responsibility for both household and children was primary to the women interviewed. Additionally, pregnancy and birth were significant in their lives. Pregnancy, birth and mothering are often perceived by the medical, social service, and legal professions as incompatible with illicit drug use (Cain, 1994; Logi, 1990; Shaw, 1985; Steinberg, 1994; Stone et al., 1971; Streissguth et al., 1994; William & Bruce, 1994). The medical profession perceives the pregnant women and her developing fetus as being in an antagonistic relationship (Chavkin, 1992; Handwerker, 1994) and the mother is viewed as incapable of making decisions concerning her pregnancy and unreliable in reporting symptoms (Oakley, 1986). In contrast, the data presented in this section suggests that mothers are initially willing and capable of making decisions about their pregnancies.  

Pregnancy and birth are biological and social acts experienced by many women. The act of becoming a mother is a social transformation that has far-reaching consequences due to societal expectations concerning mothering (Kitzinger, 1992). Women are held personally responsible by the obstetric community for the outcomes of their pregnancies (Nsiah-Jefferson, 1989). The majority of medical professionals perceive illicit drug use during pregnancy as a medical
problems rather than a social problem. Therefore, women are rarely offered social supports that could contribute to a healthier pregnancy. The fact that women who use illicit drugs during pregnancy are labelled "at risk" can have "detrimental psychological and social consequences" for the women (Wagner, 1994, p.34). Such labelling is artificial and unreliable, and removes women from their social support systems at a time when these are most needed (Wagner, 1994). Many of the mothers interviewed were treated poorly by the medical community during their pregnancy, and their birth experiences were less then positive.

The decision to carry a pregnancy to term is difficult for many women. Faced with the financial and emotional burden of a dependent child, the stigma associated with illicit drug use and possible intervention by social service and medical professionals, each of the mothers interviewed perceived her pregnancies according to her own subjective assessment of the risks involved. For some, abortion was a choice. For others pregnancy offered a new start. One young native mother on social assistance stated:

So I went out and got a test, so then I knew I was pregnant. And then right away I quit smoking because I wanted to have a baby. I wanted to have a baby that was clean. I wanted to start a new life. I didn't want to carry [on] in the tracks of my mother, you know. And I had all this burden on my shoulders....I didn't screw up. I didn't drink. I didn't smoke. I didn't drink coffee. I didn't eat chocolate. I didn't do anything. So it was a great big turn around you know....First of all...I just did it for my baby...now I'm doing it for myself.[Sue]
For the majority of the mothers, pregnancy presented conflicting choices and limitations. Two young women note:

I didn't care about my life...or what happened. Then I found out I was pregnant and I was going to have a...child. I thought, well, this is something to live for. Then I felt bad, that I was doing drugs two months into my pregnancy. So then I prayed to god "Please god, make her a normal child." And she was fine. [Cindy]

She won't be saying, "Oh you used to be a drug addict, you used to do this"...I'll just be mummy. I get to start all over. [Karen]

Although some of the women saw their pregnancy as an opportunity to stop using drugs, many were more realistic about the obstacles they were facing. Some were challenged by medical professionals when they discovered they were pregnant:

I was four and a half months pregnant, and the doctor...says "Well, Mrs. D., you are pregnant." And before I could go "yippee!" he says, "Would you like me to arrange for an abortion?" Just bang, nine years of waiting and that's what he says, would you like me to arrange for an abortion. [Marg]

In addition, as Siney (1995) and Goode (1994) discuss, many of the women in their studies on maternal drug use were unable to cease their illicit drug use during pregnancy. Others described their confusion concerning their illicit drug use when they were pregnant. Many worried that they were hurting their unborn children, though not intentionally. Abstaining from illicit drug use was more complex than just saying "no":

I became pregnant and really thought immediately that abortion...was the only sane thing to do at this point. He really fought me on the issue and thought that we could quit using drugs and go out and build a picket fence and everything would be fine. I looked at him like "Are you nuts? Neither one of us has the capability of doing that right
now." But what a nice dream, to go back to being somewhat happy and normal again. So I let him talk me out of it.[Pat]

I didn’t know what to do. I was pregnant and I was using and I didn’t want to be pregnant by myself... I didn’t want to have it. So, I thought, how can I have this? I can’t even be with my other child.[Mary]

I got pregnant when I was trying to clean up. I’d been trying to clean up for a year. But that’s the thing. They never thought about...the fact I had a problem...I wasn’t out there doing drugs to hurt the baby. It wasn’t like, "Oh, I think I’ll go get pregnant and then I think I’ll go get high and hurt this baby, so that it comes out all screwed up so everyone has to deal with my mistakes." You know, if I wasn’t prepared to deal with my mistakes I would have had an abortion...I wouldn’t have kept it. It’s just hard. It’s just really hard.[Karen]

Not all of the women interviewed had used drugs during their pregnancies. For those who did, the decision to continue their pregnancies was a challenge and was often stressful. Factual information about the effects of illicit drugs on maternal health was difficult to obtain. Many of the mothers were given information that greatly exaggerated the negative effects of prenatal drug use on the developing fetus, and many others received no information at all. One young native Indian mother explained:

I didn’t know nothing; I did the drugs till he was born. No one talked back then about what drugs are going to do to the baby. Nobody ever said anything to me....I didn’t know I was pregnant till I was six months pregnant, a month before I delivered. I didn’t show, I even had my period....I didn’t know anything; I was on the street.[Jane]

A young mother of European heritage noted:

No one ever told me. [They’d say,] "It’s just bad for it, it’ll kill the baby, and hurt the baby."
But they never told me in plain terms exactly what it did. [Karen]

As Handwerker (1994) states, physicians tend to be overly cautious in determining risk factors in pregnancy, and never remove the high-risk labels regardless of improvement or evidence to the contrary. Women who use illicit drugs during pregnancy are seen as being "at risk" regardless of maternal outcomes.

After initially finding out they were pregnant, many of the women looked for prenatal care. Although there are some supportive doctors who work with women who use illicit drugs during pregnancy, many of the mothers interviewed had traumatic experiences. Once they were identified as illicit drug users, they were treated harshly by doctors. One mother on social assistance stated:

I went in and waited for almost three hours before I saw the doctor.... I wanted help, I needed help right. And she just dug her fingers in my ribs; I had red marks...it was just like I was a piece of meat. It was just awful. I walked out of there and I forget what it was that she wanted. I had tears running down my eyes. And I thought, "I'll never come back here again, no way." And I walked out of there and I cried and I cried.... It was late - 5:30, 6:00 - before I got home. The next day, my girlfriend came home and said "what's wrong?" and I told her what happened...nobody, ever should be... treated that way. [Ellie]

Some of the women were on methadone programs when they discovered they were pregnant. Information regarding methadone and pregnancy has shifted over the years. Currently it is suggested that methadone may benefit pregnancy by stabilizing a mother's drug use; however, infants exposed prenatally to
methadone experience more severe withdrawal symptoms than infants exposed only to heroin (ISSD, 1992). In the past, women who were on legal methadone were advised by their doctors to stay on it rather than attempt withdrawal, for fear of miscarriage (Hepburn, 1993b).

Some women were told that methadone did not cross the placental barrier so the baby would not be affected by their mother’s drug use. Two long-term legal methadone patients stated:

I went on the methadone program and I wasn’t affected in the way that a lot of women are today....Of course when I went on the methadone program you were encouraged to go on....I was told it didn’t cross the placental barrier....Since then of course they found that sometimes it does, it seems, and sometimes it doesn’t, but this is what I was told. Now,...[if] I had known that it crossed...I likely still would have stayed on the methadone program....Nobody wants their child born addicted....Now, if anything, I would encourage girls not to get pregnant...when they are on methadone....But, life isn’t that simple. It’s like saying to anyone, "Don’t get pregnant." And then, the other thing that happens...is that women don’t get their period when they are using heroin....I’m embarrassed to tell you this. I was 26 weeks and I didn’t know I was pregnant. Twenty-six weeks.[Linda]

There is so much misinformation....when I found out I was pregnant, I was on methadone and the doctor of the program then was wonderful. He told me it was basically my choice of what I wanted to do. He said to me that he has a lot of experience with...pregnant women who were addicted. He said if the women were taking care of themselves in terms of nutrition and sleep...the babies were ok. Often they were a little less birth weight, probably, but it didn’t affect intelligence and all of that. He said that alcohol and cigarettes are more dangerous than my drug.[Diane]
These mothers had few choices when they discovered that they were pregnant. Abortion was not a viable option for some of the women in the study, for prior to the discontinuation of Therapeutic Abortion Committees in Canada abortion was a medical decision, not a woman's right (Brodie, Gavigan & Jenson, 1992). In addition, many women who use illicit drugs cease to menstruate, so pregnancy is often not detected until after the first trimester when abortion is not as feasible or readily available.

The information women received differed according to when and by whom they were seen by during their pregnancies. Some received accurate information, but the majority did not. Therefore, pregnancy was fraught with many fears concerning outcome and possible harm to the developing fetus.

The Birth Experience

Some of the women interviewed described the negative treatment they received at the time of birth once they were identified as illicit drug users. As mentioned above, not all of the women interviewed had used drugs during their pregnancy. In fact, the interview schedule did not include a question asking whether the mothers used drugs during pregnancy. Rather, the women interviewed were asked if any of their children were labelled NAS and treated at Sunny Hill NAS program (see Appendix D).

The birth experience for most women in Western countries is situated firmly within the medical model of health, which
increasingly relies on technology to monitor, predict and confirm pregnancy and to facilitate birth (Wagner, 1994; Oakley, 1986; 1992; Rothman, 1989; Saxell, 1994). Women's subjective experience of birth is overridden by the objective knowledge of the doctor and by technological interventions (Oakley, 1992; Saxell, 1994). For many women, including the women interviewed, birth is a frightening experience, in which they have little control over their own bodies or the place and type of birth. It was not until the 1960s that homebirths and midwives became conditionally available to women in North America (Burtch, 1994). In Canada, midwifery is still illegal in many provinces. In B.C., it became legal in 1994; however, it will take some time before schools and licensing boards are established and midwifery practice can actually begin. So the majority of women in B.C., including the women in this study, had few alternatives to the medical model of health during pregnancy, labour, and birth.

Women who use illicit drugs are considered to be "at risk" during pregnancy and birth. However, risk assessments often have negative effects on maternal health for women (Brodie & Thompson, 1981; Handwerker, 1984; Oakley, 1992). Labelling women "at risk" becomes problematic when women are unable to change their behaviour (Handwerker, 1984; Oakley, 1992). Women who are unable to discontinue their illicit drug use during pregnancy are perceived as failing to comply with medical advice, and this often has negative consequences for
Moreover, as mentioned earlier, female illicit drug users are often treated harshly by medical professionals, which subsequently influences their willingness to seek medical advice. Women identified during birth as illicit drug users have been stigmatized by the medical professionals attending them at birth. Two mothers who were on social assistance at the time of birth note:

I had a PID infection when I was pregnant. I didn't notice. I was not dilating....14 hours later and I am screaming, because I had hard labour for ten or 12 hours. [They asked if there was any] reason why [I] wouldn't dilate. I said "A couple of years ago I had a PID infection." It wasn't half an hour, I was under anaesthetic and they were doing a caesarian after 14 hours. That really blew me. It was because at first they just thought "Oh well, it is the drugs, let them wear off. Let her suffer through it and then"...you know, that was a trip. I mean it was pretty obvious, What was going on. As soon as they realized what was going on, sure enough, they took the baby out and I was completely infected inside. But they blamed the enlarged liver on the drugs only. Nothing to do with the infection...of course. [Theresa]

Well, as time went on, you know, I did get down to just snorting coke and then I would go back out on the streets and fix. It was an on-going battle trying to keep the drugs away from me. Which I wasn't able to do. And...just before she was born, I was using the most that I ever have during the pregnancy. So, I went into labour. I was still fixing. I didn't want to go to the hospital. My water had broken and I did [go]. I had so many sores all over my body. I don't know what it was that I had, but I mean sores from head to fucking toe. I looked like a leper. I was so ill. I went into the hospital and they just ahhhh!! They were like, God!...There was no point in even saying anything to these people. There is nothing you can do...to justify what you have done. You can barely justify it to yourself. And there is going to be no

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understanding whatsoever for where you have been, what has been going on. It is like...you are a leper. "We don't want to touch you"...but, then of course she was born. And it was the most painful birth I have ever had in my life....I mean I had an epidural. I had everything....I love having babies. I mean, all my children up until then, I really enjoyed their births. This was so damn painful, this was "Give me anything...to stop the pain." I didn't know...and I thought these were the stories, that my mother had told me about birth.[Pat]

For many women ceasing illicit drug use during pregnancy is a challenge, and many are unsuccessful. But continued drug use is not in itself irresponsible; as Oakley (1992) noted in relation to smoking, it is a way for many women to deal with the stresses of their lives and their domestic environments, and to continue caring for their families. Goode (1994) and Taylor (1993) discovered that women tend to use illicit drugs to cope with family life and to gain a sense of control over their situation. There is a wide range of responses and motivations for continued use of illicit drugs, including but not exclusive to positive motivations and coping motivations. Using illicit drugs to cope with social stresses does not indicate lack of agency. Rather, it suggests that women actively search for ways to enhance or alter their realities. The choice of an illicit drug over other possibilities may be shaped by social, political, cultural and economic variables.

Parenting and Guilt

All of the women interviewed adhered to the ideology of motherhood through their acceptance of their primary role as the caregivers for their children, and the subsequent guilt
they experienced as mothers who use illicit drugs. Many discussed their fear of losing their children either temporarily or permanently through child apprehension by the Ministry of Social Services. Many discussed the guilt they experienced as mothers who used illicit drugs. For those who used illicit drugs during pregnancy, and for women whose children were occasionally exposed to illicit activities, the guilt experienced was immense. Overwhelmingly, regardless of race and class, the women interviewed expressed guilt concerning their illicit drug use and its negative impact on children, friends and family:

I suffered tremendous guilt. I know that it stopped me... from doing lots of things in my life.... I just felt crippled. I never knew what that word [guilt] meant until I was 40 years old.... It is my biggest enemy and my constant companion, is guilt. [Judy]

I think I feel guilty... because of what I put my parents through and what I put my daughter through and all that stuff. [Diane]

The mothers interviewed viewed themselves as responsible for both their own behaviour and the behaviour of their partners:

Oh yeah, I felt the guilt. Because obviously I was poisoning them inside [during pregnancy], and being a mother I was responsible; I should have been responsible. Even to the point where I should have been responsible for his behaviour. Which was really stupid. I ended up feeling responsible for everything. And lost of course. It was a losing battle by that time. [Donna]

I felt responsible for everything that was going on in my life. [Pat]

Adhering to familial ideology, the women carried the total burden of parenting. This is not to imply that understanding
the role of mothering that prevails in Western culture would have allowed them to escape their guilt and feeling of sole responsibility of their children. Many of them were fully aware of the sexism that structured their lives. What is most significant is their almost universal experience of men as absent caregivers and of society’s failure to offer support. It is from this place that the women interviewed took on the traditional role of caregiver. The guilt they experienced in relation to their children was all the more painful, because they saw no viable options, especially when they were poor:

You know, when the kids were not going to school, they were driving with me. That is all they did, was travel looking for dope. And I feel terrible about that. God, I feel guilty about that....As a mother, you are going to feel guilty about using dope. I mean...you are constantly getting it from society. [Theresa]

It might have been easy for me if I had given her up from the moment she was born. Then you don’t have so many memories, regrets and guilt. [Pat]

As the one mother noted above, when women fail to feel guilt about their illicit drug use society is always ready to remind them that such drug use is not consistent with good mothering. However, as noted in Chapter three, many researchers have demonstrated that women who use illicit drugs can be adequate parents (Hepburn, 1993a; Leeders, 1992; Taylor, 1993).

Adhering to the ideology of mothering that prevails in Western culture, many of the mothers expressed their regret that their children were exposed to their activities as illicit drug users; they all felt personally responsible for
this exposure, even though the criminalization of drugs plays a large part in shaping illicit drug use. In fact, the majority of the mothers were in favour of decriminalization and were aware of the negative implications of the criminalization of drugs and of social attitudes. Still, when discussing their children, they took full responsibility for every aspect of their care. They hoped to shield them from harm and when that was not successful they felt tremendous guilt about their lifestyles.

Many of the women expressed their concern about raising children in Canadian society. They discussed the importance of educating their children about illicit drug use, and about the economic, social and political structure of Canadian society that perpetuates stereotypes about illicit drug use. Some spoke about their fears:

I had a lot of anger, but for my children, too. I’m really worried about them, too. Not really worried about using, because I plan to educate them well, but just growing up in our society. [Morgan]

The only thing I hated about my parents is they were hypocrites; "Do as I say, not as I do." And I hated that. And I’m going to try my best...I’m not saying I’m going to be perfect but I’m going to try to be honest with her, because how [else] can I expect her to be honest with me?...I want her to be able to talk to me, but how can she talk to me if I can’t talk to her? A lot of...things to learn. I want to go to parenting classes. [Karen]

And this is one of the reasons I really want to keep...the anti-prohibition movement going, because I don’t want my daughter going through what I did. I don’t want anybody’s kid going through what I had to go through. [Theresa]
The mothers educated their children, and strove for shifts in social attitudes surrounding illicit drug use. Maintaining open communication with their children appeared to be important to the mothers, especially as their children reached adulthood. One long-term legal methadone patient stated:

Yes, when she was old enough...I knew that there would become a time and to...simply ignore the whole thing would be very bad on my part. So I knew at one point we would have a good talk. Because she knew...she was in her young teens, 13, I think it was. I sat her down...and talked with her about the methadone. She was like, "I know, Mom"...probably I could have talked to her a couple of years earlier and didn’t even realize it. But she knew, you know. But she respected that I was honest with her. I think that was important....You know, [it]...would have been horribly wrong on my part to try to fool her.[Evelyn]

Many of the mothers, both single parents and mothers who had a supportive partner, hoped and strove for changes in drug legislation and social attitudes, and educated their children about illicit drug use as they reached adulthood.

Conclusion

Rather than exploring the many constraints that women and especially mothers experience in relation to their roles as caretakers, women are blamed for failing to cease their illicit (and licit) drug use. Subsequently women blame themselves. Rather than examining the social context of women’s lives, health professionals question whether a mother exhibits sufficient responsibility toward her developing fetus, and whether she has followed medical advice.
Consequently, maternal health can be seen as a matter of individual choice rather than as result of the mother’s social environment. Mothers are blamed for the outcomes of their pregnancies, and infants labelled with Neonatal Abstinence Syndrome (NAS) are subject to further medical surveillance. The following chapter will examine the medical diagnosis of NAS, and the implications of this label for both mother and infant.
CHAPTER 7 - NAS: Sunny Hill

I. INTRODUCTION

This chapter examines the Neonatal Abstinence Syndrome (NAS) program at Sunny Hill Hospital For Children in Vancouver, B.C.. Interviews with the past director of Sunny Hill and with mothers whose children were patients there inform my work. Of the 28 mothers interviewed for this dissertation, 14 children had been diagnosed with NAS. Of these 14 children, ten were in-patients at the NAS program at Sunny Hill. All of the mothers were on social assistance when their children were transferred to the in-patient NAS program at Sunny Hill and 70 percent of the 10 children were eventually permanently apprehended by the Ministry of Social Services (see Table 6-2).

This chapter also reveals how the ideologies surrounding mothering, family and illicit drugs often inform medical decision making regarding the care of infants. This chapter will examine the medical environment to which infants labelled with NAS are exposed, and the treatment of mothers by the medical and social service professionals involved in the NAS program at Sunny Hill Hospital. The mothers' perception of their infants' symptoms, treatment and long-term care will also be explored.

Both historically and in contemporary society, medical professionals have instructed women about how to behave during pregnancy and childrearing (Arnup, 1994; Davin, 1978; King,
Specifically, certain activities have been forbidden. Rarely are the doctors' instructions, advice, assessment and treatment challenged. And rarely are doctors perceived as hazardous to health\(^2\) (Rothman, 1989). For women who have been identified as illicit drug users, the arm of the law "retains its 'old' power...whilst exercising new contrivances of power in the form of surveillance and modes of discipline" (Smart, 1989, p. 17), including surveillance and modes of discipline by the medical and social service professions. The treatment of infants labelled "at risk" for NAS at Sunny Hill Hospital demonstrates how mothers are controlled and punished outside of the criminal law. This chapter focuses on the role of the medical profession and the integration of medical and social service policy and regulation.

II. SUNNY HILL HOSPITAL NAS PROGRAM

Until 1983, there was no specialized program for infants experiencing Neonatal Abstinence Syndrome (NAS) in British Columbia. The label NAS was first used by Finnegan (1979) to describe symptoms of infant withdrawal and guidelines for care. Infants in B.C. diagnosed with NAS were treated individually by doctors at hospitals, or as out-patients, throughout the province. The women in this study who gave birth prior to 1983 had a wide range of experiences that

\(^2\)See Chapter three and four for a discussion on reproductive autonomy, and the medical model and social model of health.
differed from those of women who gave birth in or after 1983. For the women who gave birth prior to 1983, the label NAS was not used by medical professionals and treatment differed depending on the doctor they chose.

Not all infants exposed to maternal drug use experience NAS. Research has found no correlation between severity of withdrawal symptoms and length and quantity of maternal drug use (Ficker & Segal, 1978; Hepburn, 1993a). What is most significant about the labelling and treatment of NAS is the perception of the mothers interviewed and the care of the infants. The mothers discussed the changes that occurred in B.C. once Sunny Hill Hospital for Children developed its NAS program in 1983.

Sunny Hill Hospital for Children, a 55-bed paediatric rehabilitation centre in Vancouver, has the only NAS program in the province of British Columbia. The founding physician of the program was its medical director until 1992. Between 360 and 372 infants were treated as NAS in-patients over the first ten years of the program (Sunny Hill Hospital Tertiary Task Force, 1993, p. 6).

In March 1992 a formal task force came together from the British Columbia Ministry of Health to evaluate the care provided by the NAS program at Sunny Hill Hospital; the Ministry of Health declared that the NAS program was both "atypical" and "expensive" (Sunny Hill Tertiary Task Force, 1993). Dr. Susan Albersheim notes that the NAS in-patient

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program at Sunny Hill Hospital was no different from other programs across Canada (Sunny Hill Tertiary Task Force, 1993)
But this is a rather general statement that overlooks the physical environment, the length of stay, and the physical care of the infants in the program. In 1992, a new medical director of the NAS program was appointed. By 1994, small but significant changes had occurred. Because it is too early to assess the current program at Sunny Hill, this thesis is concerned with the NAS program prior to 1993.

Table 7-1
Biographical data on mothers of infants sent to Sunny Hill in-patient program

<table>
<thead>
<tr>
<th>Total mothers: 8</th>
<th>n</th>
<th>%</th>
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<tbody>
<tr>
<td>On social assistance when infant was transferred to NAS in-patient program</td>
<td>8</td>
<td>100</td>
</tr>
<tr>
<td>European Heritage</td>
<td>4</td>
<td>50</td>
</tr>
<tr>
<td>African American</td>
<td>1</td>
<td>12</td>
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<tr>
<td>Native Indian</td>
<td>3</td>
<td>37</td>
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<td>Total children: 10</td>
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<tr>
<td>5</td>
<td>50</td>
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<td>1</td>
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<td>4</td>
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Denial & Lies

The founding director of the Sunny Hill NAS program explained that he began his work with infants prenatally exposed to drugs prior to 1983, at Vancouver General Hospital (VGH):

I was impressed by the fact that the mothers themselves suffer what addicts do anyway, they are
He was especially concerned with the suffering infants experienced due to their mother's maternal drug use:

I realized that nobody knew how to treat them, and not too many people cared very much. So that is how I got into it.... I came back from Harvard training in '57. So from '57 on I was in the nurseries at VGH, and than I became head of the nursery here. So...these women, I didn't treat them like savages, but more than that, I really cared about the babies.[1]

When VGH moved its paediatrics and maternity departments to Grace Hospital and Shaughnessy Hospital, the founding director continued his work there until the NAS program was established at Sunny Hill Hospital in 1983. Although the program he established was primarily concerned with the medical treatment of infants experiencing NAS, parents were also affected by their infants' stay in hospital. Although the director hoped to establish a program that would better meet the needs of the infants, and thus the parents, often his assumptions about both the infants and their parents became embedded in the policy governing the medical care of these infants. For the mothers interviewed, the policy at Sunny Hill Hospital NAS program was viewed as problematic and threatening.

It is well documented that women are reluctant to go for medical care if they fear child apprehension and personal

[22Throughout this thesis the coding number [1] refers to the founding director of the Sunny Hill NAS program in Vancouver, British Columbia.]
stigmatization (Chavkin et al., 1991; Gómez, 1994; Maher, 1992; Humphries et al., 1992; Siney, 1994). Some of the mothers interviewed acknowledged that they avoided contact with medical professionals while pregnant. The mothers' fear of approaching the medical community for help during pregnancy is further complicated by the medical professionals' belief that women lie or are in denial about their drug use (Robins & Mills, 1993; Stone et al., 1971; Williams & Bruce, 1994). As the founding director of the NAS program observed:

There is enough variation [in] what mother takes and seldom they tell the truth anyway. They may intentionally tell a lie; many of them tell lies. And they block out certain things. [1]

Lauridsen-Hoegh, the NAS program coordinator, claims that the parents of the infants treated in their program are extremely manipulative (1991, p. 15). Given the founding director's and program coordinator's frame of reference that mothers fail to tell the truth, and their position, it would be difficult for some birth parents to form therapeutic relationships with the medical staff at the program. Rather than claiming that mothers who use drugs manipulate and lie, and assuming that mothers take more drugs than they admit to, one could more usefully analyze the environment of mistrust that exists between the mothers and the medical community.

Infants labelled NAS

Infants were usually referred from St. Paul's Hospital and B.C. Children's Hospital to Sunny Hill Hospital's NAS program. Nurses, social workers and physicians identified
infants who were at risk for NAS and the founding director of the NAS program approved their transfer to Sunny Hill. Two small residential rooms had been set aside for infants labelled NAS at Sunny Hill; the rest of the hospital cares for children with acute and terminal illnesses. As mentioned earlier, 14 of the mothers I interviewed had children diagnosed with NAS. Of these, ten were treated as in-patients at Sunny Hill. The other four infants who were not treated as inpatients included one child diagnosed with NAS at a few months of age, and a set of twins were diagnosed at the age of four. These three had only been treated as out-patient at Sunny Hill. One other infant was born and treated for NAS in Ontario.

According to the mothers interviewed not all of the 14 children showed clinical signs of NAS (see Sunny Hill NAS Flowsheet in Appendix E). Nevertheless, ten of them were kept in Special Care Nurseries at B.C. Children’s Hospital and St. Paul’s Hospital, and later referred to the in-patient NAS program at Sunny Hill. Clinical manifestations of withdrawal are separated into two categories at Sunny Hill. Life threatening manifestations include explosive diarrhea; water depletion; shock; projectile or continuous vomiting; and convulsions. Non-threatening manifestations include tremors; hyperreflexia; exaggerated Moro response; excessive sweating; fever without apparent cause; sneezing and snuffles; hiccups; hyperactivity; denuding knees elbows and nose; excessive
crying; feeding, sucking and swallowing dysfunctions; lethargy; floppiness; arching of the back; intolerance of handling; skin mottling; high pitched crying; distressing insomnia; unexplained failure to gain weight; light intolerance; and coughing (Sunny Hill Hospital for Children, 1992c, see Appendix E).

However, these symptoms may not appear in infants exposed prenatally to drugs. As mentioned earlier, withdrawal symptoms are not predictable or inevitable, and they range widely. The Sunny Hill Hospital Tertiary Task Force stated that infants (360-372 infants during the first ten years) were referred to Sunny Hill if the referring hospital felt that the infant was in need of specialized treatment for NAS; if the social environment of the parents was complex and could delay discharge; if there was a past history of drug use by the mother; if there was high risk due to the ethnicity of the mother; and if there was a lack of foster care placement after an infant has been apprehended from the parents (Sunny Hill Hospital Tertiary Task Force, 1992, pp. 3,4). Consequently, many infants who were not exhibiting NAS symptoms are sent to the NAS in-patient program at Sunny Hill Hospital. Unfortunately, all infants referred to the program were treated for NAS, regardless of their lack of symptoms.

Many of the mothers interviewed appeared confused about why their children were kept in Special Care Nurseries and later transferred to Sunny Hill.
My daughter was born at 7 pounds. That is not bad, yet where was she...ICU [intensive care unit]. [There was] no reason for any of this....They kept trying to tell me that she was wired and crying...well if you had something stuck in your god damn head and you can’t move, wouldn’t you be cranky and crying too? Yeah, and I mean it was two weeks before I could even touch the baby....They kept her in for a month [at St Paul’s]. And I was really frightened at the time that I was going to lose her, that this was just...a waiting game.[Theresa]

Another mother did not see her infant for ten days after his birth:

I didn’t see him for the first ten days, but they told me he didn’t show too much of any signs.[Lori]

She had been told by the Ministry of Social Services (Ministry) that unless she went into a drug treatment centre her infant would not be returned to her, even though the infant did not appear to be showing serious symptoms.

Another mother whose infant had no obvious symptoms of NAS stated:

He [the director] has one general prescription for all babies; he doesn’t look at the degrees of damage done to them.[Greta]

Mothers were also frightened by the setting of the program and the acute patients treated there. Many of the children residing at the hospital are mentally and physically handicapped. Mothers interviewed feared that their children admitted for NAS were perceived as being as ill as the other children admitted to Sunny Hill. Rarely was it explained that NAS is transitory. One mother noted her husband’s reaction to Sunny Hill:
It scared my husband. He had no idea about this stuff, and we would go in, and he would call them broken children, he didn’t understand the ones that are slightly retarded or physically broken and it scared the hell out of him. [Donna]

Aside from the intimidating hospital setting, parents were also troubled by the environment allocated specifically to NAS infants, the medical treatment, the close alliance with social services, their infants’ long confinement in hospital and the surveillance of their care of their infants.

In-patient Stay

Infants transferred to Sunny Hill were kept in two tiny darkened rooms with no intercom system and no special care nursery medical equipment. It is interesting to note that infants who had been identified as requiring specialized care were left in an isolated room where there was no communication system set up for the nurses to contact outside help. The bleak rooms could each accommodate six NAS infants. Blackout curtains surrounded each crib, protecting the child from light and noise, and night lights were used for observation of the children (Lauridsen-Hoegh, 1991, p. 14). The infants lay in large cribs all day and night. Sound and touch was limited. Mothers, and medical staff were not allowed to touch the children except briefly at feeding, bathing and changing times. Infants were not cuddled, rocked, spoken to or brought outside the room into the light for fear that they would become overstimulated. Mothers could only speak to their children occasionally in hushed voices. Additional auditory
stimulation was guarded against. Infants were placed in this environment of sensory deprivation immediately after staying in Special Care Nurseries, which generally have lights on 24 hours a day, lots of noise, and nurses, doctors, parents and other family members visiting.

At Sunny Hill it was believed that infants labelled with NAS need a low-stimulation environment to reduce the severity of withdrawal (Lauridsen-Hoegh, 1991). Therefore, the two rooms set aside for NAS in-patients were designed for maximum sensory deprivation. Infants are kept within the blackout curtains until "symptomatically justified" (Lauridsen-Hoegh, 1991, p. 14). When the past director of the NAS program was asked about the average length of time infants stayed in the darkened rooms, he stated:

The average is not too meaningful, there is such a wide, wide variation. There are probably very few who went home in less than three weeks and some of them were here for 6 months.[1]

However, to the mothers interviewed, the length of time (up to 6 months) their infants resided in the darkened rooms was significant:

She was born at Grace [Hospital], but they moved her within a couple of weeks to Sunny Hill... she was there for five months.[Pat]

Two months in the darkened room....I put her two months behind for being in Sunny Hill because she was deprived of contact.[Donna]

She spent about two weeks at Grace Hospital. Then they found out she had withdrawal....so they took her to Sunny Hill and put her in the dark room. She stayed there until she was about five months old.[Grace]
In contrast, the majority of infants labelled with NAS in other programs in Scotland and England return home within 3-14 days (Hepburn, 1993a; ISDD, 1992; Siney, 1994). Infants perceived as no longer needing the low stimulation at Sunny Hill were sent home within a few days of coming out of the isolated, darkened room. However, parents believed that the time their infants spent in these rooms may have contributed to poor development and later adjustment problems.

When the founding director was asked if the mothers were allowed to touch their infants when they were in these darkened rooms, he stated:

There is no real allowable amount of stimulation. It's a matter of having to handle them to change their diaper and to feed them....but in the ordinary course of rocking the baby, you know that sort of thing seems to add to their stimulation. Occasionally a baby will be soothed by being rocked but...usually chemically dependent mothers do not have what many other mothers have, that sensitivity to what the baby will tolerate. So instead of being soothing, they will handle the baby and shake the baby and so on...they are devoted, but whatever it is that guides other mothers, they don't seem to have....The nurses were aware of that, and at the same time they were torn, torn by the knowledge that these are the mothers, they want to handle their babies.[1]

The ideology of mothering shapes the medical practice at Sunny Hill. Mothering is a social construct rather than a biological imperative (Arnup, 1994; Glenn, 1994). But by portraying mothering as natural, the "medical expert" can claim that certain women, i.e. women who use illicit drugs, do not possess these inherent qualities. Although the nurses found the medical protocol at the NAS program contrary to their own
knowledge about mothering and comforting infants, they were instructed that the mothers of NAS infants lacked the maternal knowledge (instinct) to comfort their own children. The nurses also adopted the expert's opinion on mothering, which denied their own knowledge. Therefore the medical protocol regulating and limiting stimulation, including touch, was enforced by the nurses and medical staff, even though there is no medical evidence supporting lack of touch in the literature on NAS.

In contrast to the program at Sunny Hill, NAS programs in England and Scotland encourage both touch and the active participation of mothers, by having the infants remain with their mothers after birth (Siney, 1993; Hepburn, 1993a, 1993b). Only a small percentage of infants whose symptoms are severe (which is rare) require more specialized care (Siney, 1993; Hepburn, 1993a, 1993b). These infants are not shielded from light, noise or touch (Siney, 1993; Hepburn, 1993a, 1993b).

Other NAS programs in the U.S. discuss the need to shield infants from direct bright lights (Greider, 1995); however natural outdoor light and bedside lights are acceptable (Lowe & Dawn, 1994). Some programs have incorporated infant massage into their treatment regimen, and parents are encouraged and instructed to touch and massage their infants (Lowe & Ehrhard, 1994). Winnicott (1987) states:

It is the physical holding of the physical frame that provides the psychology that can be good or bad....Babies do not remember being held well --
what they remember is the traumatic experience of not being held well enough. (pp. 62,63)

Winnicott (1987) suggests that infants cannot exist alone and are part of a relationship. Many health professionals that care for infants recognize that "the parent-infant pair must be cared for as a unit" (Brazelton & Cramer, 1990, p. xv). Parent-infant interaction is a neccessary component of infant development (Brazelton & Cramer, 1990; Winnicott, 1987). Parent-infant interaction and behaviour signal and determine responses, "one member acting on and shaping the other", but also acted upon and shaped by the other" (Brazelton & Cramer, 1990, p. 97). In addition, stimulation is necessary to the maturation of sensory organs (Brazelton & Cramer, 1990, p. 27.).

Outside of Sunny Hill, it is believed that human contact is essential in the care of infants labelled NAS, and that a home-like environment should be incorporated into NAS programs (Lowe & Ehrhard, 1994). Some doctors suggest that loud, startling noises should be avoided (Lowe & Ehrhard, 1994). Others have no policy on noise; therefore, the infants would be exposed to the same level of noise any other infant would be after birth (Siney, 1993; Hepburn, 1993a, 1993b).

Isolating infants in darkened rooms for long periods of time is unique to the NAS in-patient program at Sunny Hill. Most programs recognize that infant withdrawal varies in length. Generally the physiological effects of withdrawal last for 3-14 days. It is rare for it to last more than two weeks
(ISDD, 1992). Any other negative effects experienced by infants may be due to prematurity or health problems unrelated to their mothers' drug use. There is no medical reason to keep them in isolation and darkness for such long periods of time, especially given the availability of various medications that may alleviate withdrawal symptoms.

The regulations and protocol for infants' care at Sunny Hill’s NAS in-patient program concerned the mothers:

They let me hold them for a couple of minutes but they didn’t want them stimulated. [Liz]

We would go down, and have to put on these gowns and these gloves. I always refused to put on the gloves. White gloves and go in and not make any noise [Donna]

Well there was two of them in the room, but you had to keep it quiet....They had the curtains closed and you had to be quiet. [Jill]

Mothers expressed concern that the treatment their infants received at Sunny Hill was damaging to their infants’ health. One native mother was concerned that her child was never encouraged to sit up or crawl because he was confined to his crib:

He just lay there, and he got fatter and fatter. He’s not moving and they wouldn’t let him go crawling. [Jill]

Other mothers were concerned with the lack of bonding and the institutional setting, which appeared cold and uncaring:

And one of the things, too is you’re breaking the bonding, and then the mother may never bond. The baby may never bond. [Janet]

They are fed on a clock basis, and if they cry, they just go and poke a soother in their
mouth....Just a soother. They will pop it in and turn them over and cover them up again and that is it. It was cold in there too....Yes, they got the big cribs for them. You are not supposed to bother them. I took the responsibility of feeding periods which was just limited to us for half an hour and they kept the room dark and cold. I guess she had to sweat it out. Half an hour, we were gone....When your time was up, it was like you were in jail or something. You know, you just walked in and you are supposed to be really...like a matron or something. Pick up the baby, feed her, change her, put her back to bed and that was it. And they never had the babies warm or anything. It was always one little blanket to sleep with. I found it really...awful the way that they looked after the babies.[Grace]

Infants were fed every three hours. They were said to have "hypermetabolic demands," where their systems are in "fast forward," and to require structured feedings until steady weight gains were achieved according to established growth curves (Lauridsen-Hoegh, 1991, p. 15). This protocol to measure progress through weight gain directly affected the mothers and infants:

they wanted him to be fed in 20 minutes. So what if it took an hour? It was my business.[Greta]

Infants were also given a high-calorie formula when they were on medication. Progress was noted on a flow sheet (see Appendix E). About 30 to 50 percent of the infants received a paediatric opium solution, similar to Paregoric but free of camphor and other toxins, and with the alcohol concentration reduced (Lauridsen-Hoegh, 1991, p. 14). However, mothers expressed concern that infants who had not been exposed maternally to opiate derivatives were also prescribed Paregoric:
When we went in the room, it was dark at first, she was on opium and stuff, and I was using cocaine and I thought, "this is stupid....why put them on opium when it was cocaine?" And they said, "It makes their coming into the world easier"....I think it slowed her in some ways.[Donna]

Parents' expressed concerns about the medical treatment of their infants with opiates were not recognized as valid.
The founding director stated:

A chemically dependent person, male or female, does not want anybody saying...they should be doing this or that. So if I decide to put a baby on opium, they may feel "Well, this guy's not going to do that without my permission." So there was that kind of resentment; they just didn't want to be controlled.[1]

Instead of recognizing that parents had legitimate concerns related to their infants' care and the medical treatment they received in the program, medical staff perceived parents as not wishing to be controlled.

Sunny Hill Hospital also notes that NAS infants have poor sucking responses and feeding, sucking and swallowing dysfunctions (see Appendix E). However, they do not raise the question of how forced feeding and bottle feeding, as opposed to breast feeding, affects infants' sucking response. In the film "Saint Segal," a nurse is shown attempting to feed one of the infants in the in-patient NAS program. Contrary to program policy, she is roughly jiggling the infant and bottle in her attempt to get the maximum amount of milk into the infant. Babies need time to breathe in between sucking, and differ in their sucking and eating habits. Forcing them to eat within a prescribed time limit may contribute to the running of an
efficient hospital program, but rigid routines fail to address the individual needs of each infant.

As mentioned earlier, not all of the mothers believed that their infants were experiencing NAS, and many questioned the inevitability of NAS symptoms as expressed by medical professionals. Mothers noted that their infants did not always follow the pattern of NAS predicted by the medical professionals at Sunny Hill. They felt that their infants were not as "ill" or "unattached" as the medical professionals claimed:

Yeah, they try to act like just everything was because of the drugs. And I know differently. Some of those [symptoms] were just baby things...he [the director] kept trying to act like "Any day now it's gonna happen; you are going to see these symptoms." [Greta]

The founding director believed that infants experiencing NAS were unable to bond with their caregivers. Isolating infants in small darkened rooms and depriving them of touch, sound and light did not interfere with bonding because the physiological sequelae of withdrawal made it impossible for the infants to bond:

Now in a state of withdrawal they are in no mood to bond or anything, and being touched upsets them. And...I don't think it is an exaggeration to liken that situation to somebody who pays a lot of money to go to a symphony and than comes down with a migraine headache. And that's what's frightening about these babies; they are in no position to be receptive to...nurturing[1].

He also noted that:

These kids go through a social experience, which when they are old enough, I'm thinking weeks,
months...they learn to socialize in terms of making eye contact, in terms of capturing a person's attention and being affected if the other person looks away...it's a social skill which to many people would be evidence that this kid is bonding. But he's not. It's a form of manipulation. And...of course street life is like this. People watch the eyes of their victims. There's a lot of nonverbal communication in most of us. But street people go by it. And these babies aren't street people, but a person can have no loyalties to any friend, no sense of social values and anything like that, but can have a tremendous bedside manner. Be really engaging, of course that makes that person more dangerous....These babies can develop a social skill that...makes them very responsive to whoever [is] there, and yet they may have passed the time...when they couldn't possibly be attached to anybody....there comes an age when that bonding process doesn't seem to happen, and in a normal child it is somewhere around nine months of age[1]

The director confused his own ill-informed image of poverty and street life with the effects of maternal drug use. The ideological assumptions that the director held about poor people, illicit drug use, and mothers were camouflaged as medical expertise.

Infants exposed to cocaine prenatally are often said to be recognizable by their behavioural differences and their "unreachableness" in interpersonal relationships; however, Robins and Mills (1993) note that they are no different from other children from economically and socially deprived backgrounds (p. 29). Furthermore, Hawley and Disney (1992) point out that children who remain with their biological mothers are securely attached.

The mothers interviewed were especially sensitive to the fact that their infants had bonded to them, contrary to the
medical information they had received at Sunny Hill, and they
expressed their concerns at length during the interviews:

He had to eat his words, because my son was so
bonded to me that he just stared at me whenever he
heard my voice. And the director said "I've never
seen a baby that attached, that much attachment in
a baby that small." Because he would just stare
into my eyes like nobody else existed. He said he
probably wouldn't be able to look at me and they
have trouble bonding and all this stuff.[Greta]

Yeah, I remember them saying "Your son is not going
to know you," and all that. And I thought, "Not my
son, he's going to know his mum."[Ellie]

The way they told me about C., that she couldn't
make friends with people and she wouldn't be
cuddly, and she wouldn't be warm. That she would
always be...at arms length with everybody. But, I
found it really different once I started to go
there. Because she started to be really waiting for
us, it seemed. All what they said about her, was so
different. I was expecting to find a very hard
child to even hold, but she was waiting all the
time we would come. She would be [lying] there with
her eyes open and she knew that we were there for
her. I think that is what gave her the boost to
fight all the odds against her.[Grace]

Some mothers thought that the way they were instructed to
treat their infants shaped their infants' responses to them:

My friend's kid is a spoiled little brat and it has
nothing to do with dope. It's the way we react to
what they say. The rules that they give you, you
are all paranoid about them, and you react really
to what they tell you to expect....I expected it
[that her daughter would not bond] because she
wasn't home. And that's what I got. And I was in
the hospital because of my heart operation; I was
gone for three months. And when I got home, she was
"I'm papa's baby," you know. And she didn't want
nothing to do with me, but of course, at first I
blamed that on the dope, and then when I saw the
way she was with my husband then I said "This is
just because [of] how I am with her." And I've been
home nine months now. It took maybe three months
before she would put her hands up to me....But...I
couldn't see that I was treating her differently

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until I saw how my husband was treating her when I got home, and how she was with him....And I always said "Here I finally have a baby and I'm straight and she's not huggy she doesn't want me she just wants to take off." And that really wasn't the way she was at all. That was the way I was with her.[Donna]

The mothers felt strongly that the information they received from Sunny Hill about their children not bonding was incorrect. In fact, Sunny Hill's medical practice and information on infant attachment hindered bonding, thus creating a problem where one need not exist.

Although the founding director insists that it is the withdrawal from maternal drug use that impedes bonding, he concedes that the hospital setting also contributes to the lack of bonding:

Bonding has to be with one person, or a constant with two parents, or two guardians or whatever. With the shift system here, and very different ways that different people handle a baby, how they hold them and so on, their voices....in a hospital setting anyway, there is no bonding.[1]

But no attempt was made until recently to change the hospital setting or to create alternatives outside of Sunny Hill. Although the founding director told me he was concerned that the hospital setting contributed to a lack of infant bonding, he never expressed these concerns to the mothers. All they were told was that their infants would not bond due to maternal drug use and the negative effects of NAS.

The majority of the mothers interviewed felt that they were not given guidelines or offered support through participation in a parents' program that might ensure that
their infants were returned to them. This lack of guidelines created tension, for the mothers had no idea what was expected of them and decisions about their infants’ care and discharge appeared arbitrary. One mother stated that she was given no information about how to care for her baby. However, she stated that:

I’m sure if I asked them something, they would have told me. [Liz]

Given the newness of the situation, and the medicalized environment, it would have been more appropriate to give information and guidelines for infant discharge to all of the mothers upon arrival, rather than providing follow-up instructions at discharge time. As one mother stated:

They never have guidelines. It is always this open-ended stuff that it is just playing dangle, dangle with you over every fucking issue....In the first place, they pretty much ignored me. It was like I almost wasn’t there. I had trouble...even asking directions. It was like...I do have a right to be here, you know. And it happened every single time I came. It was like..."[which] child is yours? Who are you?" It didn’t matter how long you came, they still acted like they didn’t know who the fuck you were, or what you were trying to do. [Pat]

It was important that mothers visit their infants, for visits were recorded on the infants’ flow sheets and could have some influence on whether their infants would be allowed to come home. Good mothering was measured by how often a mother visited her infant, regardless of other factors that may have rendered visiting impossible. Sometimes, the nurses’ surveillance of parents was beneficial to them. As one mother stated:
The nurses were great; they kept track of every time I came up to feed him. They were one of the reasons that I got him. Because they had written such good reports. "Oh she was very good with the baby today." They marked everything down...in my favour.[Greta]

However, many mothers reported that they were very uncomfortable with the nurse's presence when visiting at Sunny Hill:

I found it really difficult...because it made it seem like you were going into a prison to visit them....You had to...just watch how you conducted yourself. Like even looking at the baby or saying hello to it or you know...putting your hand in the crib made you feel that you were doing something really awful. Like if you said hello to it. If the nurse was there, you couldn't, because it seemed like she was in there just to see what you were doing. And I really felt for those babies.[Grace]

They really hovered around me, like whenever I went into her room and held her or changed her or whatever, it was like all this constant hovering around by people who were trying to pretend, like they were not overseeing the situation. But [they] were. [It] made it so uncomfortable that it was...really hard...to stay for very long.[Pat]

The NAS program coordinator explains that during an infant's stay at Sunny Hill, doctors rely on the "observation and impressions related to them by the nurses" (Lauridsen-Hoegh, 1991, p. 14) for the clinical management of the infants. Unlike mothers in the Glasgow and Liverpool programs (Siney, 1994, 1995; Hepburn, 1993a), mothers were not trusted to record their own attendance and their own perceptions of their infant's health at Sunny Hill.

The institutional setting and surveillance of the mothers at Sunny Hill intimidated mothers. Mothers who opposed the
prescribed medical treatment for their infants were perceived as noncompliant. Furthermore, due to poverty, many mothers had difficulty visiting their infants at Sunny Hill. Many were denied bus passes by the Ministry of Social Services, and many had other children at home, which made visiting problematic. Until recently, there was no room set aside for the mothers at Sunny Hill; therefore, they had to wait in the cafeteria between feedings.

One of the powerful aspects of the ideology of mothering is that it keeps mothers in their place. There are no avenues within Sunny Hill for mothers to complain about medical protocol. Nor are there other avenues for mothers to present economic and social problems that shape mothering and attendance at Sunny Hill. Often mothering is judged on external behaviour that adheres to the ideology of mothering, which views mothers as inherently giving, pure, sacrificing and selfless (Gupta, 1995; Thurer, 1994). Few of the mothers at Sunny Hill were able to fit into the confines of this ideology. One native mother described her difficulty in visiting both of her sons, one in Sunny Hill, the other in foster care:

We didn't have no bus fare or nothing. I had to walk to the hospital...and Sunny Hill was over at Slocan and 20th, and J. was at Williams and Nanaimo....It was a long walk. And you go home and sleep and next day you try to go again. It was awful.[Jill]

Another native mother, in a similar situation, says:
Long-Term NAS Problems

The Sunny Hill NAS program lists the following potential long-term NAS problems: impaired growth rate/stunting, poor movement and coordination, abnormal muscle tone, delayed speech, impaired hearing, disturbed behaviour, hyperactivity, sleep disturbances, brief attention span, learning disorders, aggressiveness, poor self-confidence, bursts of uncontrollable temper, difficulty in making and keeping friends, and defective communication skills (see Appendix E). As discussed in Chapter four, many of these long-term symptoms are subjective and unsubstantiated. Nevertheless, medical policy is often constructed according to the prevailing ideology concerning illicit drugs. Illicit drugs are perceived as inherently dangerous. Infants exposed to illicit drugs are thought to suffer from the long-term problems listed above. In addition, mothers who expose their developing fetuses to the "danger" of illicit drugs are perceived as failing to be mothers (Rosenbaum et al., 1990).

Moreover, the ideologies surrounding both illicit drug use and mothering shape medical assumptions and policy. The past director of the Sunny Hill NAS program states:

For the chemical[ly] dependent children they don’t have a sense of security that comes through
attachment, they don't have a sense of loyalty to friends or elders. They don't have appreciation, or at least a motivation, to fit into social values in general. And lacking...in a sense of security, they tend to be very aggressive and scared.[1]

However, as noted in Chapter four, the incidence of behavioural problems associated with children prenatally exposed to illicit drugs has not been substantiated. Critics state that it is not possible yet to determine behavioural problems associated with maternal drug use (Hepburn, 1993a, 1993b; Mayes et al., 1992), for studies do not distinguish between exposure to other drugs, genetic liabilities and prenatal liabilities (Hepburn, 1993a, 1993b; Robins & Mills, 1993, p. 18). Furthermore, there is no scientific evidence that infants exposed prenatally to illicit drugs lack loyalty or a sense of social values.

For parents of the infants in the NAS program, information about their infants' development was not available except from the director and nurses. Therefore, the director's medical protocols and his underlying assumptions for establishing these protocols are important to note, especially when they were not based on medical evidence. Much of the medical treatment of the infants in program at Sunny Hill was based on "hunches," which in turn were based on ideological assumptions.
Social Services and Sunny Hill

The Sunny Hill program worked closely with the Ministry of Social Services. The founding director of the NAS program states:

When we started up here we developed a much closer relationship to the social workers...not right away, but that developed to the point where we were really one with them, very close, so that we entered into the placement of the child whether it was birth mother or foster mom.[1]

However, the native Indian community in the Lower Mainland was concerned that infants had been referred to Sunny Hill Hospital "only for social and economic reasons, and the effect of this was to place the infant at increased risk of apprehension by the Ministry of Social Services" (Sunny Hill Hospital Tertiary Task Force, 1993, p. 4). The Sunny Hill Tertiary Task Force note that approximately 60 percent of the infants admitted to the inpatient program at Sunny Hill Hospital were native Indian (Sunny Hill Tertiary Task Force, 1993, p. 7), and only one-third of the infants transferred to the NAS in-patient program were returned to their birth parents following discharge (Lauridsen-Hoegh, 1991, p. 13). As one native mother interviewed noted:

I noticed. I used to read the names every day to see if there was a white baby. There are never really any. And I really looked at it good one day and I noticed, all native. I said, "Look, all native babies." [Grace]

A follow-up program was also developed through Sunny Hill Hospital to assess these infants developmentally over time, and when parents failed to show for their scheduled
appointments the Ministry of Social Services was contacted by hospital staff.

Community representatives (native Indian and nonnative) pointed out how difficult it was for some parents to understand the hospital process, and that the poverty in the parents' lives often made it difficult for them to travel to the hospital. As well, they pointed out how difficult it was for native Indian parents who were themselves victimized through government policy, such as residential schools, to interact with social workers and medical professionals (Sunny Hill Tertiary Task Force, 1993).

Historically, women of colour have been denied the right to mother their own children in North America (Collins, 1994; Gupta, 1995; Wong, 1994). Although the ideology of mothering in Western society portrays women as maternal and giving, women of colour are portrayed in more negative terms. They have been perceived by the state as incapable of caring for their own children (Gupta, 1995). As discussed in Chapter three, Native Indian women have rarely been allowed the right to raise their own children in Canada; residential schools and later the child welfare system separated children from their families (Gupta, 1995; Monture, 1989). Although native Indian people represent less than 4 percent of the population, 51 percent of the children-in-care in B.C. as a result of court orders are native Indian (Report of the Aboriginal Committee, 1992, p. 1). The placement of native Indian infants in the NAS
program at Sunny Hill has created a new avenue for child apprehension by the Ministry of Social Services and the medical profession (see Lauridsen-Hoegh, 1991, p. 13; Sunny Hill Tertiary Task Force, 1993, p. 7).

Although Sunny Hill Hospital recognized that the mothers who have infants at the NAS program were often single parents who have few social supports, resources were allocated in the past to create a therapeutic foster parent support group, rather than a birth parent group; and the NAS program coordinator expressed concern about providing support to grieving foster parents when NAS infants were returned to the birth parents (Lauridsen-Hoegh 1991, p. 16). The grief that birth parents might experience when their infant was transferred to the NAS program and the additional grief they experienced when their infants were placed in temporary or permanent foster care were not acknowledged.

The close liaison between the NAS program at Sunny Hill Hospital and the Ministry of Social Services had other negative effects on families involved in the program. Family Court often relied on medical testimony from Sunny Hill in determining custody cases of infants labelled with NAS. The mothers' needs and feelings were often ignored in Family Court decisions. The ideological assumptions about the superiority of expert knowledge are applicable to all women, for economic problems have now become medical problems (Arnup, 1994; Davin, 1978; Myers et al., 1992; Oakley, 1992). With the advent of
the public health and maternal health movements, motherhood has become a medicalized domain. In British Columbia, midwifery offers an alternative view to maternal health and birth. Unfortunately, since the N.D.P\(^2\) provincial government in B.C. announced the legalization of midwifery in May, 1993, a midwifery school and practice has not been established (B.C. Ministry of Health and Ministry Responsible for Seniors, 1995).

In addition, ideological assumptions about "good mothers" are shaped by assumptions about race and class. Familial ideology recognizes only white, middle-class, nuclear family arrangements as the norm; all other family forms are typically unrecognized by social workers and Family Court judges (Chunn & Gavigan, 1991).

The founding director of the Sunny Hill NAS program noted that when infants were temporarily or permanently apprehended by the Ministry of Social Services, the mother would appear in Family Court:

Then they would appear in court and I would be called on as an expert witness and...in the normal pursuit of the justice system, if this was being contested by mum, then she would have some medical expert to present a challenge, but there wasn't anybody you see....I was sensitive to the fact that this was an uneven playing field for them. I'm the expert, nobody knew how to challenge me in court. I'd be cross examined...not effectively, and ah...because they, I knew everything there was to know. And the counsel for the mum would tend to just throw me off, to ask me questions just to have me lose my temper. And I don't have a temper to

\(^2\)New Democratic Party
lose. It's a waste of time. So with that imbalance I'm very careful not to say this baby should or should not go home. I merely describe the baby's special needs. I don't usually know the mum that well to be passing judgement anyway. So I describe the special needs. Then I leave it to the social worker, who knows mum better than I anyway to help the court decide whether that mother is capable of providing for those needs.[1]

Chunn and Menzies (1990) note that judges accept the expertise of medical professionals in court. However, medical professionals hold assumptions about "morality, sexuality and family life" that reinforce and reproduce patriarchal relations (Chunn & Menzies, 1990, p. 50). Consequently, women who cannot conform to the norm are punished. Because the NAS in-patient program is the only one of its kind in B.C., an opposing opinion was lacking. Judges in Family Court found it difficult to assess the safety of the children labelled NAS, and medical criteria developed by Sunny Hill Hospital were given more weight than other information (Sunny Hill Tertiary Task Force, 1993). Furthermore, the Sunny Hill Tertiary Task Force Report (1993) notes that the information gathered from the NAS in-patient program was lacking in context (p. 7). Thus, Family Court decisions were primarily shaped by the "expert" opinion of Sunny Hill Hospital, according to criteria they had constructed.

Sunny Hill Hospital staff have has been given the label "baby snatchers" by many communities in the Lower Mainland and women claim that they are "petrified" of the medical director of the NAS program [Jill]. Some of the mothers consented to
having their children transferred to Sunny Hill. But when consent was lacking, infants were apprehended by the Ministry of Social Services. One of the mothers interviewed was unaware of the Ministry’s involvement with Sunny Hill Hospital. She describes her contact with Sunny Hill:

He was born and then put in a special care unit at Children’s Hospital. The last couple of days that he was there that’s when the director got involved and that was when he basically scared me half to death. So I thought "Well o.k. I better do this then." He did tell me that once he was sent to Sunny Hill that social services would become involved and I had never had any dealings with social services as far as a social worker. I had been on welfare before and knew I could deal with financial workers. I didn’t know the power social workers had over your life. And that was one of the worst mistakes I believe I ever made in my life. I immediately lost total power over what happened to my child, what I needed to do. I just lost total power over everything. Everything from that point on was dictated to me. And it was sort of, I felt a real— with the risk or sounding paranoid - a bit of a conspiracy between the social worker and the director of Sunny Hill.[Greta]

Lack of Alternative Information About NAS Treatment Regimes

The NAS program at Sunny Hill was based on the care of the infants. Outside of telling parents how to bathe and feed their infants, no instructions were offered to parents. If mothers failed to do these jobs properly, the Ministry was contacted. The past director of the NAS program states:

We have an opportunity to, if parents come in, to first of all...teach them how to bathe the baby and feed them. And if they seem to bathe them in a very objectionable way than the social worker would be apprised.[1]

Mothers’ mistakes were reported, which contributed to an environment that was often perceived as hostile to the mother.
The medicalization of mothering has emphasized surveillance, rather than care (Arnup, 1994; Davin, 1978; Mitchinson, 1988; Oakley, 1986). Mothers who cannot learn to feed and bathe their infants according to the director's instructions are perceived as "bad mothers" who need to be monitored by the Ministry.

Though many of the mothers questioned the care their children received, they were not knowledgeable about other treatment protocols, and had no access to outside information about NAS:

I didn't know...I questioned the program...a lot...at the time, I remember feeling that there was not anything wrong with her. She seemed like a very normal baby to me. Even to the point where I didn't think she really needed all that quiet room and stuff...I didn't see anything too much wrong with her. It is kind of a sensory deprivation there. That they are doing up there. Which...see, I have never actually seen really affected drug-babies either. So, I couldn't say that the treatment that they were giving her was right or wrong. Because I had never seen the symptoms.[Pat]

Another mother stated:

We didn't know what anybody...we didn't know maybe what they were doing in Calgary, or what they were doing in Montreal, or whatever. We didn't know anyone else's research. We only knew what they told us at Sunny Hill and it was taken as God's word, kind of thing, because of course they know and they have got your baby. That's the biggie.[Donna]

Of course, the fact that Sunny Hill did "have the baby" made all the difference. Another mother described how she personalized her infant's lack of care at Sunny Hill:

I took it on as a personal thing that she wasn't getting cuddled; that she wasn't getting loved....Because of the format there...I mean, how
could I really expect a bunch of strangers to give something to her that I couldn’t give to her myself. So, I probably had a lot of issues involved but I personalized it. It wasn’t the doctors or the nurses that weren’t providing something for her...I mean it was my fault that she was there. That is the way that I viewed those things....I felt responsible for everything that was going on in my life.[Pat]

The majority of the mothers interviewed considered the care of their infants their primary responsibility; in this respect, they adhered to the ideology of mothering that prevails in Western society. So they often personalized any harm, or suspected harm, their infants experienced due to NAS, or their confinement at Sunny Hill. It is not surprising that mothers were often reluctant to challenge the medical staff at Sunny Hill concerning the care of their infants. Most felt guilty about their drug use, and feared that if they raised any objection to the way their infants were cared for they might be perceived as troublemakers and this might jeopardize their chances of having their infants returned to them.

**Patient Release and Follow-up**

After the infants were released from the in-patient program, they generally spent about two days in the lit children's nursery and then were sent home or to a foster care placement. Specific follow-up instructions were given to mothers and foster caretakers. Instructions were to be followed strictly, and when mothers did not follow them the Ministry was contacted by Sunny Hill. For single mothers, and
poor women, the follow-up instructions presented many problems.

Prior to the discharge of any infant from the in-patient program, a conference was held. The special needs of the infant were explained to the parent or foster caretaker. The discharge meeting was attended by the Sunny Hill paediatrician, the medical director of the NAS program, the parents or foster caretakers, community health nurse, a Ministry social worker, Sunny Hill Hospital social worker, Sunny Hill's NAS clinic nurse-coordinator and any other health care professionals or support workers involved with the family (see Appendix E). When there were child protection concerns, or the infant had already been apprehended by the Ministry, the Ministry was considered the primary stakeholder at the conference. The discharge conference was not held if the infant was discharged to an experienced foster caretaker. Rather, a community health nurse informed the foster caretaker and the Ministry of the infant’s needs.

The Sunny Hill follow-up care guidelines listed the following areas of concern: Sudden Infant Death Syndrome (SIDS), poor resistance to infection, medications, screaming, secondary withdrawal, community health nurse follow-up, developmental follow-up, and medical follow-up (see Appendix E). Sunny Hill Hospital believed that the risk of SIDS for infants labelled NAS was eight to ten times higher than nondrug infants (Sunny Hill Hospital, 1992b). It was believed
that the infant needed to sleep in the same place, with the same time patterns, and the infant needed to be in a smoke free environment; all cigarette smoking was to take place outside. Immunizations were delayed to six months of age (though this policy was under review in 1992).

The founding director of the NAS program at Sunny Hill describes his medical protocol for protecting NAS infants from Sudden Infant Death Syndrome (SIDS):

I'm very strong on keeping the baby at home, developing regular sleep patterns, in the same place. Apparently being in a different bed, a different room, can make enough difference. And whether that has a relationship to SIDS we don't know. But, I'm pretty strong on that and a few other points which are hunches on my part. So far none of them are proven.[1]

In contrast to these views, many researchers claim that there is little or no relationship between maternal illicit drug use and SIDS (Brown & Zuckerman, 1991; Hepburn, 1993a; Humphries, 1993; Mayes et al., 1992).

The founding director at Sunny Hill claimed:

There is animal evidence for a susceptibility to infection, for animals that were born to mothers who were given drugs during their pregnancy.[1]

It was believed that infants labelled NAS had poor resistance to infection; therefore, these infants were not allowed to go to "shopping malls, churches, health clinics or anywhere there may be unnecessary contacts" (Sunny Hill Hospital, 1992, p. 2). Contact with other people besides the primary caretaker was limited. The fact that the infants were exposed to many different medical staff during their stay at the in-patient
NAS program was not addressed. The nurses who cared for the infants were on shifts. Therefore, infants might have three different nurses caring for them in one day, and these nurses might not work consistent days or nights. Consequently, the next day the infants might be exposed to a new set of nurses. Upon release from Sunny Hill, the founding director advocated that:

For the first five or six months, first of all the daycare thing is really out, because that's where people exchange all these viruses....and if mom has to go shopping at the supermarket it is better to have someone come in, particularly from a SIDS standpoint.[1]

Most of the women were told that they could not take their infants out for one year; this was also confirmed by many foster caretakers who had NAS infants. However, for women who lacked social support and access to financial resources, enforced isolation was difficult to maintain.

None of the infants labelled with NAS were allowed any medication, including over-the-counter medication, unless it was authorized by a doctor. It was also claimed that these infants labelled NAS might become "screamers," developing a high-pitched cry that could last for hours, no matter how much the caregiver attempted to care for them. Mothers and foster parents were instructed that swaddling the infants, protecting them from noise and light and, most important, having another person available to provide relief for the caretaker would help when the infants became inconsolable. These instructions
may appear to be helpful; however, most mothers had little access to "relief" as a foster parent might.

Sunny Hill Hospital also expressed concern about secondary withdrawal in its follow-up instructions. It was believed that infants labelled with NAS might experience a second withdrawal up to six months of age. However this withdrawal might be difficult to detect, for it might "mimic symptoms of potentially life-threatening diseases" (Sunny Hill Hospital, 1992, p. 3). Caretakers were advised to go immediately to emergency or contact their family doctor. The founding NAS director claimed:

The secondary withdrawal may be worse than the first, or more often less intensive. And it may take the form of diarrhoea, crankiness, increase in crying at night, a lot of them, there's a lot of tremors.[1]

When asked how he distinguished between secondary withdrawal and flu, colic or normal tremors (as some of the infants are premature), he responded:

A lot of them are [premature]. Basically, I don't think we bat a hundred in differentiating here. If the baby's showing signs, then the chances are the signs will disappear if we went in for the darkened room for a few nights and that kind of thing. In other words, remove as much of the stimulus as possible.[1]

This response does not establish whether secondary withdrawal actually exists. The symptoms described are exhibited in healthy children who have not been exposed to maternal drug use (Morrison & Siney, in press; Weston et al., 1989). As well, most infant illnesses will subside within a few days. So
is it the passage of time or the darkened room and the administration of opiates that is effective? Is it a normal infant illness or secondary withdrawal that the baby experiences? The fact that the symptoms subside while the infant is in the darkened room does not establish the fact of secondary withdrawal.

Mothers were given all of the above instructions prior to discharge of their babies. The "special needs" of these "at-risk" infants were often both frightening and difficult to care for. The whole structure of the mothers' lives changed when their infants were released to go home:

They told us we had to really be careful with him, not to have loud noises like T.V., music...what else was there? And we had to keep him like in a dim, dark room. Not as dark as the one in the hospital, though. [Lori]

They gave you these rules and regulations when you bring him home. How to care for him, how to approach him, how to touch him, how to keep him wrapped tight. To avoid the noise, the T.V. and vacuum cleaner and stuff like that. Loud groups of people and stuff like that. I was just scared. Everything the paper told me to do for NAS, it was like I can't just go out, I can't take my son out, I can't go visit my family....I was just so afraid because I couldn't go anywhere, I had no transportation. I couldn't take my baby on the bus, couldn't do anything. Take him to the store. I mean, it was like I was locked in this place, and the place I had was just half of this whole space, one little bedroom, one little living room with a kitchen. [Ellie]

For the mothers interviewed, the follow-up guidelines were very difficult to adhere to. Their lives became very regimented and isolated, and the support that they might have received from friends and family members was no longer an
option due to rigid medical rules surrounding contact, crowds and visiting.

As mentioned earlier, much of the care and medical protocol established by the founding director at the NAS program at Sunny Hill was based on "hunches," based in turn on ideological assumptions, rather than scientific evidence. Nevertheless, the mothers had to comply with the established medical protocol, for fear of losing their children to the Ministry. As the founding director observed:

The fear of my helping the court to have them lose their baby, that's a real threat....More and more mothers have learned not to get into the net [to come to the attention of medical professions] because of the fear of their baby being apprehended.[1]

Although the mothers' fear of apprehension by the Ministry was recognized, it was not addressed within the NAS program at Sunny Hill. Rather, child apprehensions were considered to be justified due to the infants' special needs, and the program was not modified to welcome mothers rather than frightening them away.

**Follow-up Assessment**

All of the infants were given their first developmental assessment at four months of age and the last one at eight years of age. These assessments were conducted at Sunny Hill Hospital by "specialized therapists" and the infants were assessed at the NAS Medical Follow-up Clinic at Sunny Hill. Follow-up appointments were often stressful for both mothers and children. One native mother stated:
The first check-up with me, we were in the treatment centre. And it was really, it was really stressful for me and for them....I didn’t know what was gonna happen; they didn’t tell me what was gonna happen. We all just went into these rooms, and they separated the boys. And the people who drove me to Sunny Hill, they had to stay with J. in one room, and we were in the other room, me and G. And so J. was getting real scared because he didn’t know anybody. And it was just the people who drove us there, and it was real scary for him so he wasn’t participating with them....16 months [old], he didn’t know anyone. So they left the door open, and they were both in the same room, and they were both screaming....And it was really hard, and all my stress went to the small of my back. And oh, I felt real small because of what they were asking me, cause I don’t know how to play with my kids or nothing.[Jill]

[They are] 16 months. I don’t know where they get off saying that they are the way of a 13 month old. Just because, I heard this one guy on the bus when the babies were babies right, they were small, he said they didn’t start walking till they were 17 months old, his child. And 13, 14 months my boys were walking, and it made me happy because the guy said his baby didn’t start walking until he was 17 months old. And so every baby is different. I don’t know where they get off in trying to test them, like they are testing. If they test another baby whose mother never used drugs or alcohol or smoked, [it] probably would be worse than what these guys were.[Jill]

After release from the NAS in-patient program, the mothers and infants were visited by community health nurses in their homes until the infants were 11 months old. The nurses were instructed to measure the infants’ weight, length, and head circumference, and to monitor for SIDS and silent otitis media (inflammation of the middle ear), which they believed occurred more often in infants labelled with NAS. Any deviation from the usual growth curve was considered a possible sign of "impending SIDS" (Lauridsen-Hoegh, 1991, p. 303)
16). The founding director claimed that the public health nurses:

picked up things we wouldn't here, seeing the baby in the home....and the nurses were terrific, they would phone me if there was nobody home when they got there or if they were having problems. [1]

The surveillance of the mother's behaviour continued long after her infant was released from the program.

The community health nurse provided duplicate copies of the NAS flow sheet to the family doctor of the parents or foster caretakers, at her own discretion. For all the medical concern expressed for these infants, parents were not offered any type of parenting or support group to educate them or to lend them support, either when their infants were in the inpatient program or later when they came home. For some parents, the infants never did come home, but were placed in foster care. Lauridsen-Hoegh (1991) claims that only one-third of the infants went home to their parents, and many of these children would spend a period of time in foster care first. The rest of the infants were "adopted as special-needs children" (p. 15).

The fear of infants being apprehended by the Ministry was present at all times. Although an infant might be able to return to the birth parents' home upon discharge, mothers were not secure that this arrangement would continue. Community health nurses and Sunny Hill Hospital contacted the Ministry whenever a mother failed to show for an appointment, or when they had child protection concerns. As one mother stated:
There would be nothing I could be caught at. But I was still really paranoid, so I was over cautious about following by their rules... Not to go to crowded places, no noises, keeping her structured. [Donna]

Although mothers attempted to follow the instructions laid out by Sunny Hill Hospital, there was no guarantee that this would be enough to ensure that their children would not be apprehended after discharge. One mother expressed her frustration about the community health nurse’s visit. Her child always became upset when the nurse undressed, weighed and measured him. The mother began to undress the child herself during the visits because he was more tolerant of her touch. One day she left her infant in her mother’s care during a community health nurse visit. She describes the visit:

So one day she came to do her whole trip and my mom was there. So my son was really agitated when she went to do her procedure. And she went and reported to the director that J. seemed really agitated today and I wasn’t there. The director wrote a letter to my social worker and said to her that if anything... my son was high risk and if he died my son’s blood would be on her hands. They thought the baby was going to die. That was a crock, Susan, it really was. I really watched my son, and really got to know my son. I was with him as much as I could be with him during that time. Out of guilt I wanted to see how much damage I could detect, so I really got to know my baby you know, and it wasn’t true. He was really a fairly normal baby except for the diarrhea... as soon as he [the director] got that note from the health nurse, he just turned on me like I couldn’t believe. [Greta]

The medical staff at Sunny Hill, the community health nurse and social services accepted that the infant’s care always took precedence over the mother’s concerns.
Resistance

All of the mothers interviewed whose children were sent to Sunny Hill Hospital were on social assistance, with little access to other economic and social supports. Unequal power relations between the mothers and the medical and social service professionals, the mothers' economic situation, isolation and a lack of formal education, often contributed to difficulties in negotiating with the medical and social work professionals involved in their infants' lives. Often what appeared to be a minor incident to the staff at Sunny Hill would be quite traumatic to the mother involved. One mother describes an incident at Sunny Hill when her son was there:

I was coming down with the flu. I had a headache; I could feel the cold coming on and I thought if I take two aspirins then I'd be o.k. But when I got to the nurses' station and asked "Can I get two Tylenols, or two aspirin?" and they said no. And I said "What do you mean no, this is a hospital. I know you have Tylenol in there." And they said "No, you can't have it." I said "I can't believe this. I have one more feeding before I can go home, and...I don't want to have to go all the way to Burnaby." And they said "we can't give it to you." So I called my mom, and said "Mom, can I come and get two aspirins?" She said sure.

So I had to go home. And I made explicit arrangements with the nurse that I would be back in two hours to feed my son, and not to feed him till I got there. They said, "Yeah, o.k. no problem." So I went to my mom's, and came back. And in between I missed the bus...I kept calling the hospital and saying "I'm coming, so don't feed my son." And when I got there, she was feeding my son. Well, I just went into a rage. "I thought I told you not to feed my son." So we got into an argument. So I stomped out of there, looking for the social worker, or whoever, to say, "Why did you do this?"

And [the social worker] was at a conference in Chicago, and they got her on the phone: "We've got this raging woman and we want her out of here." And
they had the maintenance man and the security standing there in front of the door and the women standing there holding my baby. [Telling me] "You get out of here, you don’t belong here." I was so upset, I said, "Lady you have my baby in your hands; you put my baby down now." And she was screaming at me, and I was screaming back at her. And I went to walk back in and the security said "Please come out; you are disturbing the other babies." And I said, "Right," and I walked out. She was still standing there with my baby in her hands, saying "You get out of here." And I said, "Lady you better put my baby down." And finally she put my baby down. And I said, "Don’t ever talk to me that way with my baby in your arms." And I told her, "I have the right to be here anytime I want to be."

I was just furious. I think I still have what I said and what she said on a piece of paper, because I knew that this wasn’t right. [Ellie]

Many of the mothers discussed the positive support they received from one of the social workers at Sunny Hill. Unfortunately, this social worker was not always available, and could not change medical protocol. Nevertheless, her support was invaluable to many mothers who had few advocates and limited options.

Although the mothers interviewed were often powerless to directly challenge the medical care of their infants at Sunny Hill, they were not passive. Rogers and Buffalo (1974) note how people develop techniques to fight against bureaucracies. Similarly, the women interviewed individually resisted interference in caring for their infants as much as possible, given the relatively powerless situation they were in (i.e., that if a mother did not comply with the experts, her child was usually apprehended by the Ministry). One mother describes
her initial visit with the founding director of Sunny Hill immediately after she gave birth to her son at Grace Hospital:

He came in with a little beard, whiskers showing, and no teeth and I had my son with me and I was in the room by myself. It was dark, nine o'clock. The baby was sleeping, and I was there, and I was just happy. And then he came in and just freaked me out. No white jacket or anything to identify him. And I said, "Who are you?" And he said, "The director." And at that point I didn't remember what Dr. said, the name of the doctor that was going to come see me. So I said to him, "Can I see your driver's licence?" So he showed me his driver's license, but that still didn't mean that he was a doctor. He said, "I understand, it's quite all right." So when he walked out I followed him, and I saw through the window that he was behind where the counter is and he was talking to the nurse. And I thought "Oh my god! This doctor is so busy, and I threw him out!" [Ellie]

Often mothers chose to resist specific instructions they did not agree with and attempted to create loving relationships with their infants despite the institutional setting at Sunny Hill. Several mothers described their attempts to care for their infants there:

And there was no talking to them... We were not supposed to, but we did... They told us to just keep it quiet in there. I know a lot of times I wanted to laugh when I was in there, because you know, I put a big diaper on C., and it came under her armpits. I couldn't help but to laugh. We used to visit one little girl that was a mixture of white and Chinese in there too, so every time the nurse was gone and she cried, we would visit with her too and give her [a] soother... they were the two noisiest ones in there after a while. They would talk to each other and you could hear them laugh. I guess we kind of stimulated both of them. You know, built them up. [Grace]

The whole thing was that they made you feel really scared to touch your baby. But I loved my baby, and I'm going to touch him and I'm going to be there. [Ellie]

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No, they let me hold her and part of that was because I was aware that she was borderline after talking to [the director]. They tried to do that several times, the quiet room and no this and no that...."Leave the baby. Don't get the baby agitated." Well...my argument, I think it is pretty agitating for the baby not to be held. It is really agitating for me not to be held, so I am getting held.[Pat]

The mothers attempted to incorporate their own values and parenting skills whenever possible, regardless of the rules and medical protocol they were told to follow both at Sunny Hill, and at home. As described above, the mothers touched and spoke to their babies when nurses were out of the room and when they were allowed to bring their infants home some of them disregarded the follow-up rules. Their resistance to medical protocol was not due to ignorance or passive aggression; it was an acknowledgement of their own beliefs, values, parenting skills and assessments of their infants' needs, which often differed from those of the staff at Sunny Hill, community health nurses and social workers. Although the mothers lacked medical training, their assessments of their children's needs appeared to be fairly accurate, and reasonable.

It's the drugs!

Other mothers whose infants had not been labelled with NAS, but who had a history of drug use, expressed concern that due to their past history of drug use doctors failed to search for other reasons for their infants' ailments. Morrison and Siney (in press) also discovered that symptoms exhibited by
infants being monitored for NAS are automatically attributed to withdrawal. One mother’s infant was quite jittery a few weeks after birth. Her doctor assumed her infant was experiencing withdrawal and suggested giving the infant tranquillizers. She stated:

It just didn’t seem right with me and I ended up going...in the Fairmont building. This big red-haired doctor...he suggested taking him off milk and putting him on soya bean milk. Well, it was like day and night....Because he was a drug baby I don’t think the other doctor...they don’t look to other things. [Linda]

Another mother discussed her concern when she visited her doctor on three separate occasions because her child appeared to be having difficulty breathing:

I undressed her, because I assumed she was going to be, you know, examined. And he didn’t. He just sat at his desk and he says, "Oh now, it is just the methadone. It will pass." It was then that I got another doctor....I explained what was happening, and that was at 12:30 at night. And he says, "Meet me at the Children’s Hospital...now"...and she had pneumonia in her left lung. [Evelyn]

Other mothers whose children had not been diagnosed at birth with NAS were now being told that their children’s later illnesses might be due to maternal drug use. One native mother states:

It was suggested [by nurses at Children’s Hospital] that my daughter’s asthma could be from my drug abuse. I don’t know, that could be inherited, or brought on by stress. [Cathy]

It was also suggested by the nurses at Children’s Hospital that this same mother’s four-year-old twins might have NAS:

Signs are just coming out right now with their behaviour problems and hyperactivity [Cathy].
Mothers reported being advised by daycare workers, teachers, social workers, nurses and doctors that behavioural and physiological symptoms that their children displayed were signs of NAS. These professionals did not consider the effects of economic and social deprivation. Maternal drug use and the failure of the mothers to protect their children were perceived as the root of the children’s problems. Rather than search for more complex answers, the social and health care professionals involved in the lives of mothers and children labelled NAS act according to ideologies that misrepresent maternal drug use, mothering and poverty.

III. CONCLUSION

Although mothers often individually disagreed with the medical protocols developed at the NAS program at Sunny Hill Hospital, no significant changes occurred. The new director of the NAS program at Sunny Hill is establishing new policy. It is too soon to evaluate the changes in the program, although the recent B.C. Chief Coroner’s Report (Cain, 1994) portrays the current program in glowing terms.

In the past, mothers who challenged rules and policy were often perceived as noncompliant by the staff at Sunny Hill. Child apprehensions by the Ministry were seen as justifiable due to the infants’ special needs and at-risk status. However, NAS special needs and medical criteria were developed by Sunny Hill Hospital, and there were no other medical professionals available to challenge them in Family Court. So mothers were
at increased risk of child apprehension by the Ministry once their infants were transferred to the NAS program at Sunny Hill. Despite the fact that many infants transferred there were not exhibiting signs of NAS but rather had been transferred for other reasons, including a lack of foster care placement.

Furthermore, medical treatment in the care of the infants labelled with NAS was often based on experimental treatment and "hunches" lacking in scientific validity. These "hunches" were based on ideological assumptions concerning mothering, illicit drug use and poverty. Many of the mothers believed that the long periods of isolation, darkness and sensory deprivation to which their children were subjected were a form of punishment and child abuse, rather than medical treatment. Medical personnel at Sunny Hill often contacted the Ministry of Social Services about mothers' perceived noncompliance. The mothers rarely had advocates to whom they could turn to with their own concerns.

Overall, the medical treatment of NAS infants at Sunny Hill, the darkened rooms, the sensory deprivation, the length of stay, the forced feeding, the lack of contact with families, the failure to provide mothers with a clear and understandable protocol to follow, the fear of child apprehension, the surveillance and control of mothers and the ideology of the founding director of the NAS program contributed to an environment of hostility towards the mothers.
and experimental treatment of their infants. It would be difficult to distinguish long-term developmental problems due to maternal drug use from the effects of infants' length of residence in such an environment. At the least, these infants were denied contact with their families, and the mothers deprived of their infants. How much damage was done to these infants during their stay has never been established.

What is most telling is that the ten infants in this study transferred to the NAS program came from families on social assistance, that 40 percent were native Indian and 70 percent of the children were eventually permanently apprehended by the Ministry of Social Services. The practice of inflicting inherently punitive and experimental medical treatment on vulnerable communities has an extensive history in North America. Since 1992 the program at Sunny Hill has been revised. The Sunny Hill Tertiary Task Force (1993) was critical of the NAS program and the new director has made small changes. This suggests that the mothers were not alone in their assessment of the NAS program at Sunny Hill.

Medical models of care that use their own criteria to establish "risk" and "special needs" have increased the social control and surveillance of mothers by monitoring the care of their infants. Once an infant has been taken away for in-patient medical treatment, his or her mother has few options outside of complying with treatment protocols if she wishes to have her infant returned to her. Mothers are monitored and
controlled, and if they do not comply with medical advice they are punished.

Historically, poor women and women of colour have often been denied the chance to mother their own children. In the treatment of NAS at Sunny Hill hospital, mothers were denied the chance to care for their own children. The promise of the return of their children was used as an enticement to enforce compliance with a medical program embedded in class, gender and race biases. This program failed to address the real needs and social context of both infant and mother. Programs that exclusively subscribe to medical models of care, as opposed to client-centred and client-directed programs, disregard the social realm in invoking science to justify their policies.
CHAPTER 8 - Social Services: Intervention and Regulation

1. INTRODUCTION

In the preceding chapter, the NAS program at Sunny Hill Hospital for Children was discussed. It was evident that the health professionals at Sunny Hill worked closely with the Ministry of Social Services when infants were labelled with NAS. This chapter will further explore the role of social services in the lives of women who use illicit drugs. These women are vulnerable to social service intervention even when their children have not been labelled NAS. Seventy-one percent of the mothers interviewed were receiving social assistance. Of these, eighteen percent were either attending university or college full-time or participating in full-time volunteer work (see Table 6-1). Social service intervention, child apprehension, foster care and the effect of losing one's child will be examined. Additionally, the women's earlier experiences as children in the care of the Ministry will be revealed. In Canada, many children and women come into contact with social services. Social service intervention and Ministry apprehension of children can play as much of a role as the criminal law in regulating poor women.

In contrast to the middle-class and professional women in this study who were nonvisible illicit drug users, the poor women who were identified as illicit drug users were challenged by social services in relation to their mothering.

In Canada, many social service professionals equate illicit drug use with poor mothering that places children at risk (Cain, 1994). Therefore, many poor women and women of colour, as well as the women in this study, have had their children apprehended by the Ministry at birth or later, and placed in temporary or permanent foster care. For those women who were themselves raised in foster care, social services represents oppression. First Nations women define the Canadian welfare system as an extension of the criminal justice system, for both punish people by removing them from their families and communities (Monture, 1989). Social services are also perceived as an extension of the policies reinforced by government residential schools in the past. Many First Nations children were removed from their families and communities and placed in these schools. Foster care in Canada has offered little protection for children. Many children have been moved from one foster home to another. Many have been physically and sexually abused in their foster homes (Report of the Aboriginal Committee, 1992).

II. PAST SOCIAL SERVICE HISTORY

Social Service intervention of mothers comes in many forms: child apprehension, provision or denial of assistance,
crisis grants, surveillance and forced participation in programs (for example, drug treatment, parenting and life skills programs). Many of the women interviewed for this study had negative experiences with social services, having been wards of the court in their youth. Some had run away from abusive home situations. Two women of European heritage noted:

I was with my mom, but I ran away. I started running away when I was 13. [Julie]

I was so unhappy as a kid, I kept on leaving home. Maybe I should rephrase that. My home was just an empty shell. There was nothing there to hold me. Shooting junk at 14 gave me a lot more comfort than my home did. Leaving home at 15 was the best thing I ever did for myself. [Hope]

Rather than turn to social services or other professionals, these women left their home environments. Other women were taken from their families and placed in the care of the Ministry. These women discussed the fears related to their own histories as wards of the court, and their fears for their children. One native Indian mother explained:

You know it was so hard to bond with anybody because we were switched around, home to home....When that happens like so many times, and finally you do get to a place that you know that you're supposed to settle down at, it's really hard. Because your emotions have been played with, and you're just a kid, right, and you don't know any different. And it's really hard on you. And I think what the Ministry's plan was that we'd all be together. And then slowly, one by one, they took us separately away. Yeah. And the youngest ones were adopted out first because younger kids are easier to adopt. I was too old to be adopted, you know....I always thought that it was the foster parents that were, you know taking me away from my mother...and I didn't really realize it was the social worker and stuff. I ah, I used to hate when they used to come and take me away. I used to cry...
all the time. Cry for my mum. I cried for my mum for years and years and years. Used to cry every night. [Sue]

And a woman of European heritage explained:

Yeah, yeah. So, they ended up in Social Services. Which is a lousy way to grow up. I grew up in Children’s Aid. It did me no good. It probably made problems worse for years afterwards. I found no comfort from any home that I ever lived in. No safety, no real life. And I would never want that to happen to my children. You know, I would do anything to avoid that. [Pat]

Some of the women spoke about the physical and sexual abuse they survived while in the care of Ministry. Foster parents were not always what they presented to social services. One young woman from a middle-class background who was placed in foster care stated:

And most of these foster homes, they sure put on a good show for social workers and government, but as soon as the worker’s out the door and you’re left alone, it’s like "You’re living in the doghouse and we’re keeping up this bedroom for appearances and we make two thousand dollars to have you here." [Karen]

Two native women noted:

I really enjoyed it there and I was there for six years, except the only thing that was wrong with it was that I was being abused by them. Physically abused. [Sue]

I was sexually abused...in a group home. They [social services]...asked me what I wanted. I said, "I wanted my real family." They said, "O.k., o.k., just say in the statement that when you ran away that you made up the statement about the foster father touching you and doing all this other shit to you and breaking your arm. So you write it all up and we’ll make sure you get what you want." And all I wanted was to get out of there. So that’s what they did. [Cathy]
Many of the women attempted to resist the abuse they received while in foster care, though their youth and powerless status left few avenues open. One native woman described her attempt to survive while in foster care:

You know we were disciplined by...getting the belt, getting punched out, or whatever. That was our discipline. And um, she quit doing it after a while and it was you know the foster dad that was doing it. Finally you know, I stood up for myself one time and I pulled a knife on him and said, "Don’t come near me, you know I’m tired of this. I’ve been abused all my life and I’ll call the cops on you. You know, I’ll call the social worker on you." So from that day, I never really got...I did get hit and stuff but ah, not a lot.[Sue]

Aside from physical and sexual abuse, children in the care of the Ministry were vulnerable to racism in the foster homes in which they were placed. Monture notes that racism is a form of violence. As a Mohawk woman, she finds racism more difficult to talk about or deal with than sexual and physical violence (Monture et al., 1993). She states that "You can’t touch racism, you can’t see it, so it’s never ‘real’" (Monture, Thornhill, Williams, 1992). The racism that many of the native Indian mothers interviewed experienced after they were taken from their homes and communities is evident in their responses:

I grew up in a town where there was a lot of racism. I was adopted by white people who hated Indians. We were more like slaves than kids to them.[Cathy]

We were taken away...bused up about 200 miles from where we actually lived....We were in really bad shape. So it made me feel really oppressed [prejudiced] against the government and the way they handled us. We suffered a lot of abuse....When
I first got to the boarding school we were stripped at the door and made to walk in and...deloused.[Grace]

I think that they treated the natives wrong...Like they treated my mom...wrong. I remember one day she was having one beer, right? Then they took us away. Like she is having one beer. That is all she had. They took us away. That was unfair, just because she was native. And one beer doesn't mean you have a right to come into the house and just take us away. I think they mistreated my parents. I think that when you are native, you are labelled right away.[Cindy]

First Nations and other women of colour were subjected to racism when they were children. Unfortunately racism did not end when they reached adulthood.

The majority of the First Nations women interviewed had experienced overt and covert racism as adults when dealing with social service agencies:

I just got a new worker and I think she's prejudiced against me because I am native you know....I feel really bad when people talk bad about native people....Some of it is true that native people have a lot of drinking problems and stuff. And that makes me feel bad as a person because that reflects on me, you know. That's the first impression that people have of me...and in fact it isn't true. And I like to make myself look different from that, you know. And I want people to know that, yeah, I am native, but I can do things too....So I think that she is, I don't know....Racist, yeah. Because the way she looks at me, and the way she acts around me, you know. The other worker I had was really nice. When I asked this new worker about the same things [services she had been told by her previous worker that she was eligible for] she goes "No that's not true."[Sue]

I know there is no doubt, no doubt in my mind that native Indians really get it in the neck. I mean first, they are first to lose their kids and not get them back. You know that they are the first to be whisled.[Theresa]
It was an issue. I believe if we hadn’t been black they never would have come into my mother’s house and taken my son. When I said to my social worker, “How dare you go into my mother’s house. You’re trying to act like she didn’t know how to raise my baby.” And she said, “Well, she didn’t do so good with you kids, did she.” [Greta]

A lot of people think I’m white cause I really don’t look Indian, right. As soon as I show them my status card or tell them I’m Native Indian, well [snaps her fingers] their attitude changes just like this, right. [Jane]

They thought that I couldn’t raise her, because of my being native. They thought that she would probably be better off in a white home. [Grace]

Racism was prevalent in the cases of First Nations women, and women of colour who negotiated with social services. This had negative effects on both mothers and children. First Nations women in particular experienced mistrust, hostility, denial of services, surveillance and child apprehension.

Deserving and Undeserving Women

Female welfare clients are subject to "gender specific forms of social control" (Edwards, 1988; p. 221). The social workers’ power lies in their ability to label women "deviant" (Amir & Biniamin, 1992) and "deserving or undeserving" (Chunn, 1995). The assessment of mothering and proper female roles is integral to welfare policy (Edwards, 1988; Maher, 1992; Maier, 1992). When women first approach the Ministry of Social Services for assistance, many are unaware of the array of interventions that this act might provoke (Gordon, 1990a). Receiving assistance opens the door to surveillance by social services agencies. Women are judged according to their fitness
to care for their families and their adherence to feminine virtues (Chunn, 1995; Thane, 1978). Some of the women interviewed were aware of the unwanted surveillance to which they would be subjected when applying for social assistance:

I had a lot of knowledge, and luckily I had a lot of friends that were supportive, and I didn’t fall into that thing where they could have taken him away from me. Maybe somewhere deep down inside I knew to stay away from them. For me, they take babies away from people, and I’ve done drugs, and I’ve done a lot of drugs. [Morgan]

All of the mothers who were visible drug users stated that once their drug use became known to their social workers, the relationship changed for the worse. Therefore, many hid their drug use from financial aid workers (if there are no child protection concerns, welfare recipients are only referred to financial aid workers):

They never knew. I always, I always made sure that I hid that. [Julie]

I always kept that separate right up until...probably the month before I asked my family to keep the kids. [Pat]

I just kept that to myself. I didn’t want social services...involved. [Cindy]

Women who use illicit drugs describe their encounters with social workers as negative experiences (Hepburn, 1993a; Maher, 1992; Taylor, 1993i). Many women’s illicit drug use became known to social services through health insurance claims for drug treatment, NAS diagnoses and application for other services. Social workers have requested that illicit drug users be identified. One social worker states: “Early
identification of these people [would be] possible if it weren’t for the ethical consideration of confidentiality" (Cain, 1994, p. 39). Fortunately, confidentiality still exists to some degree in relation to criminal charges. But the confidentiality of women on social assistance who use illicit drugs is rarely respected by medical and social service professionals.

Cain’s (1994) interviews with social workers in B.C. reveal that "services available to these families are numerous" but that in the case of the illicit drug user, "these services are seldom accepted until the effects of her addiction are blatantly threatening the safety of her children" (Cain, 1994, p. 39). Many of the women interviewed noted that once social services became aware of their illicit drug use or legal methadone use, they were treated differently, especially when asking for other services:

And once they saw the tracks on my arms, and my hands when I was signing for my check, they never gave me job searches. They just gave up, just totally give up on you. [Karen]

Even with my social worker she knows about my past, and it ticks me off, ‘cause she treats me like dirt. [Jane]

Oh yeah, they hate us. We don’t ask them for anything. Because they say, "What did you spend your money on? Heroin?" [Marg]

She brought it up a lot, that was her main topic of conversation, my drug problem....And at that point I was clean. [Gloria]

Revealing their illicit drug use, or having it brought to the attention of social workers, had negative consequences for the
women interviewed. They were denied services and treated with less respect. They also discussed how their children were used for leverage by social workers to assure that they had no choice but to comply with workers' demands once their illicit drug use was known. One native woman noted:

All through this, I felt like I had a gun to my head cause you know, because of my circumstances with social services. "You've got to go through treatment, you've gotta finish it. You gotta do this. If you don't finish, this is your last chance. You don't get no more chances after this." So you're gonna have to do it or say good-bye to your kids. [Cathy]

One native mother describes the type of surveillance she experienced when her children were returned to her after a temporary child apprehension:

Then she had a court order on [me] requesting the medical history of my children, which I signed documents for. I think that she was really negative to me. Then their school history, to see how they attended school and how their progress was. Then she had a criminal record pulled on me. Done. See if I was a criminal. I signed all those. You know, it was quite stressful on me, because...she didn't give me an easy time. Then I had a worker from parent project come down and see me for about three months and keep an eye on my home, and see how I was doing. She wrote a report about me and she said I was very oppressed [prejudiced] with the human resources. I was very sorry that I forgot to say I was oppressed [prejudiced because], of what happened to myself as a younger person. [Grace]

Single parents, poor women and First Nations women are most at risk for social service intervention and child apprehension (Maher, 1992; Maier, 1992, Monture, 1989). In Canada, doctors and nurses often inform social services if there is suspected maternal drug use (Williams & Bruce, 1994).
In this way, the providers of health care and social services collaborate in regulating and policing women (Gómez, 1994; Maher, 1992; Maier, 1992; Humphries et al., 1992; Chavkin et al., 1991). Women who use illicit drugs are reluctant to reveal their drug use, for rather than being given support, they are punished when their drug use becomes known. In addition, when women are arrested on narcotics charges, their children are often apprehended. In this case the criminal justice system and medical and social services agencies intersect in regulating and controlling women who use illicit drugs. The interests of mother and child "have been perceived by the state as separate, and often in conflict with each other" (Kasinsky, 1994, p. 98). Many of the women who have had contact with social services perceive social services as more problematic for them than drug laws. Some of the women stated:

Oh, social services. I slipped away from them for a long time though. It wasn’t until we [participant and partner] were fighting a lot that they caught on to what was going on. And that was because it was visible. [Donna]

Oh, I think social services is worse, because they have way more power, even if I had gotten into trouble with the law, at least you get to go to court and get your case heard and have a lawyer plead your case and stuff like that. But with them, they have total power. [Greta]

It was social services that made my life a nightmare. Like I felt that they were trying to intimidate me. Like there was something that I was trying to hide. [Grace]

The criminal justice system and social services often act in tandem. Both are feared. Twelve percent of the women
interviewed stated that both that drug laws and social services are an equal threat to them (see Table 9-2). Two women of colour noted:

Both the same. 'Cause it was usually the cops first, cause they call social services when...they're done with you. [Jill]

They are both heavy in my life in a sense that both of them have the ability to control what I couldn't or could do for a long time. [Mary]

However, 44 percent of the women interviewed stated that they were more concerned about drug laws than about social service intervention (see Table 9-2). In contrast to studies that focus on poor women who use illicit drugs (Maher, 1992; Taylor, 1993), white middle-class women who are not receiving social assistance, social service intervention seems remote. Middle- and upper-class women who were interviewed noted that the law and the fear of arrest were their primary concern. These women, having other social and economic supports available to them, had no need of social services. Their middle-class lifestyles mediated their illicit drug use, and they were not visible users:

The law, no question....It was the law that could easily destroy people's lives....Recommendations could be made via the law....I think the other thing that is important when we look at class differences is that because I came from a background where people had their own houses and had money to live, they didn't have to approach social services for money. [Debbie]

The law was more my fear. I was scared of them. I was totally afraid of them. [Sarah]
Poor women and women of colour felt the full impact of social services intervention when their illicit drug use became visible. Many of the women noted that the criminal law was regulated by due process and accessibility to lawyers, even if they were legal aid lawyers. In contrast, social workers appeared to make arbitrary decisions, had little accountability and were able to intimidate the women, especially in relation to child custody:

The social services doesn’t say to you what they mean. They will tell you in the most indirect way they can, because they’re not dealing with a person when they’re dealing with you, they’re dealing with whatever you’ve done. You’re not viewed as a person...they’re not going to talk to me the same way they talk to their peers. Because I’m not their peer.[Cindy]

Half the time, they don’t even know what their guidelines are. You ask them to outline the situation, it is all of a sudden "I will have to get back to you"....Anything to avoid a direct answer to anything I want to know from her.[Pat]

You wouldn’t believe it how many times I had to get on the phone and argue with those people about something. My check wouldn’t be right. They would tell me, "Oh you can’t have this," and I would say, "I’m a single mom, I’m entitled to this, and I know my rights. And if you don’t give me my rights, I will appeal this."[Ellie]

The lack of guidelines, information and due process contributed to the women’s sense of vulnerability when dealing with social services. Many of the women were unaware of their rights. Those who did challenge social services discovered that knowing your rights did not always facilitate change.
III. PREGNANCY, BIRTH AND SOCIAL SERVICES

Poor women in Canada have few socio-economic supports to which to turn in relation to their caretaking role and household responsibilities (Gupta, 1995). Approaching social services often brings unwanted intervention and child apprehension. In Canada, there is little social responsibility for the care of children and for household work. Women's work in the home remains unacknowledged and unpaid, and mothers feel individually responsible for their children's care and for household break-up (Glenn, 1994; Gupta, 1995). Women who use illicit drugs are particularly fearful of approaching social service agencies for relief due to the likelihood of punitive intervention and child apprehension. The majority of fathers in this sample failed to support their children economically and emotionally; mothers had few resources to draw on outside of their own families and friends. One women of European heritage whose child was apprehended by the Ministry of Social Services sums up the difficulties facing mothers who use illicit drugs:

I think that there is a big gap in the support for women. Particularly mothers, before they get to the point where they're using drugs. I mean it takes a pretty desperate situation to make you change or slide into drug abuse. And I don't think that there is any...help in that in between time. You know, not totally losing it....I have found that there was no place for me to go, knowing that I was getting into trouble with drugs. Knowing that my children as a result were going to get into trouble.[Pat]
For the majority of mothers interviewed the care of their children was primary. The loss of children and the struggle to keep their children were at the forefront of their concerns related to illicit drug use:

Having the responsibility of raising children, I mean that is to me the most important thing, and it’s a wonderful thing. But we’re not really deemed even able to do that as women...who have, you know, been drug users. Everything is taken away, everything is taken away...I feel that I’m really lucky, I’m really lucky that I have my children. I’m lucky, but I’m still scared. [Morgan]

People die, you know. People suffer, but is that worse than having your children taken away permanently? Well Jesus, I would probably drop off the Lions Gate or something if they took my kids permanently. I mean that is what is keeping me going right now. It is a hard fight and I am tired of it. It is a hard fight. [Theresa]

I thought God, if I lose F., if I ever lost F., especially knowing what it feels like to lose one, it devastated me. [Jane]

If you make that commitment to be clean and stuff. And you know to really try and change your ways, you have to change everything, you know....I don’t want to get into trouble with the law any more, you know I have a baby. The last thing I ever want to do is lose him...He’s the most important thing to me. [Sue]

The mothers’ fear that they might lose their children was justified, given the high child apprehension rate and frequent separation of children from mothers due to incarceration and NAS (see Table 6-2). The drudgery of household duties and the sense of sole responsibility that the women experienced were accompanied by strong bonds of love and commitment to their children. For the majority of the mothers their children were
a stabilizing force in their lives. Most importantly, their love for their children was accompanied by their fear of loss.

Child Apprehension

Child apprehension, whether temporary or permanent, is one tool that the welfare system wields when a mother is deemed unfit or undeserving. In Canada, child welfare laws define and legislate what is considered "good parenting" (Pulkingham, 1994, p. 92). Social workers and the courts, through these laws, do "intrude into the so-called 'private sphere' of many families" (Pulkingham, 1994, p. 92). Poor women and women of colour - especially First Nations - are most likely to be scrutinized and to have their children apprehended by the ministry and sent to foster care.

There is an emerging body of critical research sceptical of the foster care system (see Gupta, 1995; Hawley & Disney, 1992; Humphries et al., 1992; Maher, 1992; Noble, 1992; Report of the Aboriginal Committee, 1992; Chavkin, Allen, & Oberman, 1991; ACLU, 1990; Monture, 1989). Cultural genocide and the physical, sexual and emotional abuse of children in foster care has been emphasized. So has the punishing of mothers who do not conform to dominant ideologies of motherhood.

For poor women and women of colour, keeping the family intact is difficult due to economic and social deprivation. Of the 59 children born to the 28 mothers interviewed, 35 percent were no longer in their custody. Of these, 43 percent was permanently in the care of the Ministry, and the other 57
percent was in the permanent custody of relatives. Twenty-five percent of the mothers had their children in temporary care of the Ministry at some point in the past. Twenty-eight percent of the mothers had been separated from their infants for long periods when their infants were in-patients at Sunny Hill Hospital’s NAS program. Of the 10 children admitted to this NAS in-patient program, only three remained in the custody of their parents (see Table 6-2). In total, 36 percent of the mothers had been separated from their children at some point due to child apprehension, relinquishing custody to relatives or NAS in-patient care.

When children were apprehended, mothers had to appear in Family Court. Unlike criminal court proceedings, summary proceedings in Family Court are often an open forum to discuss a woman’s personal life in negative terms, regardless of the successes she may have had. One native women stated:

The thing with Family Court, right, they can bring up your past....I didn’t think I had a chance in hell to get them back. They’re saying, "She was a prostitute in the past, she’s been busted um, you know 27 times for soliciting. She’s done time for it, been busted for possession. Her boyfriend is a known drug dealer and she’s still involved with him and she left him (her child) with this guy, not once, but twice." And they really made me look bad, right. And, "Well known to the vice squad." And I thought I don’t have a chance in hell.[Cathy]

Women labelled "deviant" and "undeserving" by social workers were vulnerable when they appeared in Family Court. Other women discussed the format of Family Court and the likelihood of losing custody for failing to arrive in family court at the
specified time even when the mother was not informed of the hearing:

I never heard anything about it. Their excuse for that was that they couldn't find me to get in touch with me....she was apprehended at a time that I was doing time in Oakalla....by the time I got the letter, the court date had passed so they never made me aware of the court date. But I was in prison on that court date. I could have been transported from the prison to the court. But there was no attempt ever made, as far as I was concerned....they send me the letter after the fact, saying "this has all been done, because you didn't appear in court."[Pat]

The mothers' failure to contact social services and to appear in family court was perceived as evidence of their lack of caring and unstable lifestyle.

When a mother's illicit drug use became known to social service professionals, pregnancy and birth became more complex. Medical intervention was usually initiated, and infants were often separated from the mothers and apprehended, especially after they had been labelled NAS. When children were thought to be "at risk," a social worker would be assigned to the case along with the financial aid worker. An open file [social service file for child protection] would be kept until the child was no longer considered at risk. Many of the mothers noted the difference in surveillance and regulation once a social worker, rather than just a financial aid worker was involved in their case. One native mother stated:

Well before, they didn't even care where I was living. Until after the babies were born, right....it's good they care about the babies and
how they want them to live, right. But it was really hard for me, for them to take them away. [Jill]

Concern for the mother was secondary to the social service intervention mobilized around the children, especially once they were labelled NAS. As one of the mothers noted:

I’d just be really reluctant now to tell anybody, and you’re really in a bad spot. You want to tell them because you want the medical help for your baby, but on the other hand, by going for medical help, you stand to lose your baby. [Linda]

Rather than risk losing their children, some mothers choose not to inform doctors or social workers about their illicit drug use during pregnancy:

That’s why I had to lie. Absolutely. Our social worker thought an addicted drug baby is an abused baby. [Marg]

It is not unusual for social workers to perceive maternal drug use as a child protection concern (Humphries et al., 1992; Maher, 1992; Maier, 1992). One social worker interviewed in the recent Chief Coroner’s Report in B.C. stated that "Perhaps we should assume that it [drug use] is always a child protection concern" (Cain, 1994, p. 39). However, illicit drug use itself does not equal poor parenting (Leeders, 1992; Hepburn, 1993a; Taylor, 1993), nor does maternal drug use have negative effects on all infants (Hepburn, 1993a, 1993b; Latchem, 1994; Myers et al., 1992; Siney, 1994; 1995). Many social factors influence maternal outcomes and parenting

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2 Any infant labelled Neonatal Abstinence Syndrome (NAS).
skills. And many social workers confuse the effects of the drug laws and poverty with the effects of illicit drug use.

Once a child has been labelled NAS, social service intervention was inevitable. The compliance of the medical community with social workers is evident in many of the hospitals in Canada, where the two work together. This ensures that children labelled NAS will be assigned social worker:

It was the social worker at Grace [Hospital] and the head nurse who said the kid sneezed and has diarrhea. "We know that woman was using drugs, we'll send the baby away." [Donna]

One native mother described her social worker's demands upon her infant's discharge from Sunny Hill Children's Hospital:

They were trying to get involved...my social worker finally made...ten contracts between me and him and it wasn't even a Ministry stamp on it. It was just between him and me. And he said I had to sign it...in order to get the baby home. The place had to be clean, drug and alcohol free environment, and that I had to be clean and sober. And I had to have a telephone in my place before the baby could come home from the hospital. What else was there? There was a lot of things there that I had to do, a support group, and that I attend A.A. meetings. And this was all his own idea....And I told him to go screw himself. [Lori]

Another woman on social assistance was charged with kidnapping her own child after she ran away with her child, who was in the Ministry's care, during a supervised meeting at the welfare office. In fear that her next child would also be taken by the Ministry, this mother checked her son out of the hospital where he was being observed for evidence of NAS:

One [child] I took her from the welfare office, the other I checked her out of the hospital...I had someone who was ready to pick me up, and I just
walked out with her. They found me a month and a half later. They...weren't gonna give me any chance to have her at all. And yet how could I prove I could look after her if I didn't have her, right?[Liz]

The mothers who had their children apprehended were often denied a chance to prove that they could be good parents. Mistrust of the Ministry increased as mothers were denied access to their children and as it became apparent that the Ministry failed to reveal its true intentions when it apprehended their children. One woman of African American heritage stated:

The woman had really lied to my family when she came and took the baby. Because she told my sister that the baby will only be gone for a few weeks, at the most 30 days. And we'll place him in his grandmother's care, his father's mother. And my sister said that she promised...that within 30 days we would have my son back. But as soon as we went to court she went for a six-month order, you know she had no intention of giving him back. And so, what happened was they got their six-month order and by then I guess I had come down enough that I really had time to talk to a counsellor and stuff. And she told me, "Maybe this is good; maybe this can be used for you to really work on yourself and you'll get to visit your son and stuff like that." So I thought, "Maybe this is o.k." First I went to detox, and dried up again...I went to Aurora and I really thought that now I'm showing them that I'm really working hard. But nothing changed. I never got any more visiting time. For a year and a half.[Greta]

Informed by disease models of addiction, social workers were reluctant to believe that the mothers could cease their drug use. Many of the women discussed how this deterministic view affected them and their children:

People can't understand it, when you are screwed up. When you are not, you are not. They seem to
think that somehow, like there is a residue of everything. You know, they need to see months...of you not doing stuff before you get...to spend time with your kids....Like when I am screwed up, I am really screwed up and as soon as I am not, I am not. It is that simple and that quick. They say you can't shut it off and on, well I can.[Mary]

But, they didn't comprehend that you could just stop, just like that. I just stopped. She says, nobody can stop. I said, "I beg your pardon?" I mean some of those social workers are pig headed....I mean as soon as they hear that you are into drugs, they don't think that you can stop. You see, when I lost him, I stopped freebasing completely. I didn't go back to it. I didn't want it.[Julie]

I heard she [social worker] phoned Sheway [a community project for women and children] yesterday. She was asking the social worker there a whole bunch of questions like she asked me the other day. 'Cause I told them I need a break from the baby and I need to take care of a whole bunch of things. And she said o.k....She asked me if the baby was born addicted and I said, "No he was substance free when he was born. He didn't go through any withdrawal." And that was the first thing she asked me. And I got on the phone with her and said, "No, that's why he is home with me."[Lori]

The women interviewed stated that social workers were ill-informed about illicit drug use and their misconceptions coloured their decisions. Mothers were often denied custody of their children due to their history as illicit drug users. There was little room for negotiation and mothers stated that there was no way to "prove" that they were capable of caring for their children once they had been labelled as illicit drug users. Separation from children often led to increased use of illicit drugs. As one mother whose children had been permanently apprehended by the Ministry stated:
There should be some way to prove yourself. If you’re away from your kids, it’s more destructive, for them and you. [Liz]

However, as stated above, many of the women realized that there was no way to prove themselves, even if they followed all the rules and carried out all the requests of their social workers. One African American woman described her attempt to reunite with her infant son, who had been apprehended by the Ministry due to her illicit drug use. After completing a drug treatment program she expected to gain access to her son:

I went through the program and then they expected me to come out and get a house where I would be able to bring J. Or where they could bring him to visit, and where they could check out the place and make sure it was o.k. So I did that, and I was doing all the things that were required of me....I couldn’t believe there was no reward for me for doing all the stuff that I was doing. Nothing changed, and it was really hard. So, I did relapse. I was really honest about that stuff because I felt it was best to be. I didn’t know that there was a kind of game you could play as long as you kept up the appearances it was o.k. And that is not my nature. I’m just kind of "what you see is what you get." Every time I would tell her I had relapsed she was like, "I can’t trust you." It was getting so bad between her and I, and we just had a big blow up and I went to the area supervisor. I just went as high as I could to say, "Look I hate this woman, and you better get me another social worker because I’m not responsible to what I do to her because she’s got too much power over my life and I hate her guts." They said, "Just wait till after Christmas".

...so after that she went to some foreign country and I got another social worker who was really great. He was a man, and he just started the whole thing from scratch. He didn’t really read all her notes and stuff. So I had a clear slate to work with him. [Greta]

Another mother of European heritage who had three children permanently apprehended by the Ministry noted:
You get your kids taken away by welfare, you have a hard time living up to their expectations. O.k., with my son I was doing exactly everything that they wanted me to do to get my son, but...[it] was never good enough.[Julie]

Other mothers had difficulty visiting their children once the children had been apprehended by the Ministry. One native mother stated:

That hurts the mum really bad. Cause I was totally lost for six months when they were gone....They put them in Surrey. As if I had a car to get over there every day. And...I had asked the worker, "Can I see them more than one time a week?" And she says yes. But the transportation to get over there, and the lady only wanted me to go in the morning. And in the morning you have to have a two-zone, three-zone ticket to get over there, and I don't have the money for that. And they wouldn't give me the money for that. Cause it was over a hundred bucks for the passes.[Jill]

Both mother and infant suffered due to the social workers' prejudices, and many children were left unadopted because of the negative and often unwarranted stigma attached to prenatal drug exposure. One native mother stated:

I told them I didn't want them going from... home to home to home to home. Who would adopt a child the way they made her. Her medical history looked, you know. A red junkie mother.[Grace]

Approaching social services for financial assistance did not alleviate poverty; rather, women discovered that they were barely able to subsist on their monthly subsidy. One mother noted that the financial assistance she received was not enough to feed and house her children:

I mean you can't live in poverty like that for long. You either lose hope or turn to some other desperate measure, to change the situation. And [that] usually meaning getting into trouble with
it. You are left with so few options and almost every one of them has a bad ending. You know...if I could have got that financial support from welfare when I could not feed my kids for a week out of every month. When I could not even think about buying...a luxury like cigarettes. Something too high priced and out...of the possibility. You know, when food, just daily nourishment was a problem; when...you couldn’t find a place that they would give you the rent money for and they were all shitty fucking dives...and now they are giving the foster parent who has got K., they are giving her like two and a half times as much for one kid as I was getting for two. I don’t see the point in all of that. What did they solve for me? Nothing, you know.[Pat]

Due to their fears regarding the negative treatment their children might receive in the care of the Ministry, many of the women attempted to place their children in the care of relatives when their illicit drug use became problematic. Some of the mothers had placed their children with family when they were too young or traumatized to care for them, or because of cultural practices and expectations:

He was with one family for a while, and now he’s with my aunt so I don’t feel so bad....My aunt has him, and he has six brothers. He’s in my family now and now he’s excellent. You’d never even know he has anything wrong with him.[Jane]

I just talked to my mom again. We are going to rotate. One week I will have her Wednesday and one week Thursday.[Mary]

He was with my family, but now I found out he is in foster care caused he wouldn’t listen to my parents. Right from birth he was with my family. I didn’t feel like part of it. I was just a kid and there was too much anger cause how I got pregnant and everything with all the rape and all those things. Ahhhhh.[Lori]

**Separation and escalated drug use**

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As discussed above, it is common practice in the Greater Vancouver area to remove children from their mothers' care if there is a history of illicit drug use, or if the infants have been labelled with NAS. To regain custody, mothers are expected to enter drug treatment programs and attend parenting classes in order to convince social services that they are responsible parents. However, even when mothers follow the rules, their children are not always returned. In addition, the removal of children from their mothers often has an adverse effect on the mothers' stability. When children are apprehended by the Ministry the mothers' drug use often escalated, and their sense of stability ended:

Oh, I just gave up. I just thought I was no good and...that I wasn’t going to be a good mother for him....I was so terrified about my own family background with alcoholism and that I wouldn’t be able to do a good job bringing him up. I just went deeper into my addiction.[Julie]

You know, then I said, well, she is gone, and I just went right over-board.[Mary]

It was about three weeks, almost a month. It was real bad. And me not seeing them is bringing me more down. And more using I got, right.[Jill]

I didn’t know there was another 200 feet to go to the ground after I lost the kids. I really did think that it would...make my life easier. Instead, it just pulled the bottom out from underneath me. Yes. They were my only link to normality. To behave any way normal, and keeping some amount of security and stability in my life. When I lost the kids, I lost the house, the car, the jewellery, everything, and within a week, I was a street hacker, you know...There was no reason to be anything different. I was totally, devastated. I fucked my life up. I fucked my kids lives up. I was an unfit parent....So...I just dove in to the drugs of course...to deal with all the emotional [stuff]. It
doesn’t matter. I could be in total hystérics and fix, and emotion gone. Just gone...yes. So...life pretty much became a quite a haze for me.[Pat]

When I was into drugs to cover the pain. I just want to die after losing the kids. I just want to die.[Julie]

The social stigma of losing one’s child is secondary to the pain experienced. Having no legitimate way to express their pain upon the loss of their children, and few choices, many of the women increased their drug use in order to suppress their anguish. When mothers are unable to complete treatment, or fail to discontinue their illicit drug use, they fail to regain custody of their children. Thus, the initial separation of mother and infant has negative consequences with far-reaching effects in determining custody for women who use illicit drugs. Without support, many mothers begin to internalize the message that they are unfit to parent:

And I really don’t know what happened but somewhere along the line I got scared. I got scared that maybe they were right and I was an unfit mother, and maybe I wasn’t the best thing for my son. And so I began to sabotage myself.[Greta]

Conclusion

The underlying power struggles and race, class and gender issues inherent in social service policy must be addressed. Currently, women who receive welfare are portrayed as an underclass of uneducated, single parents who are out of control, sexually promiscuous and cunning (Gorlick, 1995; Martin, 1991). They have been accused of continually having children in order to stay on welfare and of regularly cheating
the welfare system (Gorlick, 1995, Martin, 1991). Women receiving social assistance who are identified as illicit drug users are perceived as unfit mothers and their children are judged to be at risk. The interests of the child and mother are often portrayed by social workers and family court judges as separate and in conflict with one another (Kasinsky, 1994). judges.

Most social workers are white, middle-class women making decisions about other families, cultures and lifestyles (Almonte, 1994). Often their perceptions of abuse and neglect come from their own limited and narrow ideas about the role of mothers and illicit drug use. Social workers typically had little education about cultural differences, drug use and family formations outside of the heterosexual nuclear family. Their ignorance has negative consequences for women who come in contact with welfare agencies.

The identification of maternal drug use and the labelling of NAS, have increased (Chasnoff, 1988b; Chasnoff et al., 1985; Graham & Koren, 1991; Nulman et al., 1994; Peak & Papa, 1993; Robins & Mills, 1993; Williams & Bruce, 1994). As a result surveillance and intervention of social services in the lives of poor women and women of colour have expanded. The current attention to maternal drug use rarely supports mothers in need of economic and social assistance. Rather, it often contributes to increased drug use and instability in the family.
In Chapter three, and Chapter four, it was suggested that a social model of care is necessary for supporting women who use illicit drugs. Social workers might be included within the social model of care as both Hepburn (1990, 1993a, 1993b) and Siney (1994, 1995) have done in their programs for mothers who use illicit drugs. But, as long as social workers and social policy identify illicit drug use and behaviour outside of traditional female gender roles as deviant, women and children will suffer. What is needed is nonjudgemental social and economic support, not surveillance and punishment. Finally, focusing solely on maternal drug use deflects attention from the inherent race, class and gender bias underlying social services and society at large.

Many of the women in this study entered drug treatment in order to gain custody of their children from the Ministry. Others entered treatment voluntarily in order to cease or stabilize their drug use. The next chapter will present the opinions of the women interviewed regarding the drug treatments they received.
CHAPTER 9 - Drug Treatment?

Introduction

This chapter presents the experiences of the women interviewed in relation to drug treatment. Many of them had to participate in drug treatment programs in order to regain custody of their children. Others voluntarily entered treatment programs in order to cease their illicit drug use. Some entered drug treatment through probation orders. Topics discussed include drug treatment, methadone services, drug use, withdrawal and cessation, and alternatives to current drug treatment policy. The final section examines harm reduction philosophy and the acceptance of illicit drug users in decision making related to drug treatment.

I. DRUG TREATMENT: EXPERIENCE AND USEFULNESS

In North America, illicit drug use is predominantly viewed as a medical and/or legal problem (Alexander, 1990; O'Hare, 1992; Peele & Brodsky, 1991). The legal model views illicit drug users as criminal and the medical model is based on the "addiction as disease" philosophy. Although these two models appear to be incompatible, North American drug laws and drug treatment programs have incorporated a disease/criminal model of addiction (Alexander, 1990).

Although there is no substantial evidence to support a biological or genetic mechanism that accounts for addiction, drug treatment services have adopted the philosophy that addiction is biological, progressive and permanent.
Drug treatment therefore requires abstinence. Treatment for licit and illicit drug use in North America has become a thriving industry, despite of its low success rate (Alexander, 1990; Brecher et al., 1972; Peele, 1989; Peele, 1989; Peele & Brodsky, 1991; Rodgers & Mitchell, 1991). Peele (1989) notes that drug treatment success rates as defined in terms of continued abstinence are less than 10 percent. The majority of drug treatment research has focused on males and findings have been generalized to include women (Addiction Research Foundation, 1994; Reed, 1987).

Critics of the disease model philosophy state that both women and men have a wide range of experiences in relation to drug use (Alexander, 1990; Hadaway et al., 1991; O’Hare, 1992; Peele & Brodsky, 1991; Weil & Rosen, 1993). A person’s relationship to drugs may be positive or negative and this may shift according to personal expectations and environmental influences--set and setting (Weil & Rosen, 1993; Zinberg & Harding, 1979). Most people who use alcohol or other drugs develop healthy relationships with their drugs of choice and are able to use them recreationally without fear of escalating or problematic use. However, a small minority of drug users, at certain times, do develop problematic relationships with drugs, and this can be very frightening. One middle-class woman in her late forties described her relationship with drugs:

I am stuffing myself...like somebody stuffing themselves with food. When it comes to drugs,
alcohol and cigarettes, it's insatiable....I have
to keep doing it, doing it and doing it. And
doing...it fills it up. It fills up...I am
terrified to go out. I'm terrified to stop. Just
like in a snow storm. I was thinking about this. In
snow storms, there is a fucking blizzard out, it's
big time. It's dangerous. Ok, I say my life is very
dangerous. In a snow storm, if you keep going, you
can't see, you might have an accident....But, if
you stop, somebody can hit you from behind. I mean
it is just as fucking dangerous. You have got to
keep going. So, what do you do in a snow storm? You
don't stop. You keep going because the worst thing
to do is stop....It is just like...like I'm living
in a snow storm, I feel like I'm fucking driven.
[Judy]

It would be misleading to omit the small percentage of drug
users who find their drug use problematic and painful. The
majority of the women interviewed had experienced problematic
and negative drug use. Problematic drug use can be devastating
to both the individual and her family. Any person raised in a
family where problematic addiction existed will attest to the
pain witnessed and experienced.

The image of the problematic drug user has been
popularized by the media in North America (Alexander, 1990;
Erickson et al., 1987; Waldorf et al., 1991). However, rather
than contributing to our understanding of drug use, the
stereotype presented by the media has limited our
understanding. Not all women feel driven by their drug use,
even when they are dependent on illicit drugs. Nor are
patterns of drug use static. The reasons why people use drugs
in a dependent and addictive manner are complex and
individual. Where one woman may trace her addiction to
familial abuse, another may have had a happy home life. Not
All addiction is negative and problematic. Many of the women interviewed were able to normalize their lives and stabilize their drug use even though they were physiologically addicted.

Both compulsory and voluntary drug treatment are often offered to people who use drugs. The components of drug treatment may include detox, abstinence, counseling, residential treatment and drug maintenance. Traditionally, in Canada, drug treatment embraces a disease model. Abstinence and relapse prevention are primary. The majority of the women interviewed for this study had participated in some form of drug treatment, ranging from individual counseling to Alcoholics Anonymous (A.A.), detox, methadone maintenance and residential drug treatment.

In response to the question "Do you think alcohol and drug treatment is effective?" the women interviewed were quite adamant about drug treatment reform (see Table 9-2). When asked whether drug and alcohol treatment is effective, 18 percent (5) of the women said yes, 50 percent (14) said no and 32 percent (9) of them thought drug treatment might be effective if treatment policy changed radically (see Table 9-2). All of the women interviewed gave suggestions for drug treatment reform and many gave descriptive examples of their own experiences in drug treatment. Few believed in the disease model of addiction, and even fewer accepted the philosophy of

Addiction: "a behavioral pattern of drug use characterized by overwhelming involvement with the use of a drug" (Jaffe, 1985, p. 533).
A.A. and N.A. (Narcotics Anonymous). A wide range of drug maintenance and treatment options were discussed, as was the view that acceptance of drug use, rather than treatment, was necessary.

Table 9-1
Interviewees who found alcohol and drug treatment effective

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<tbody>
<tr>
<td>Treatment was effective</td>
<td>5</td>
<td>18.</td>
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<tr>
<td>Treatment was not effective</td>
<td>14</td>
<td>50.</td>
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<td>Treatment might be effective</td>
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<td>if treatment policy changed</td>
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<tr>
<td>radically</td>
<td>9</td>
<td>32.</td>
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Some of the women interviewed noted that drug treatment and A.A. had been useful to them:

Yeah, I think it works. 'Cause when I did make that decision I can still draw on a lot of the information I got there. [Greta]

If I didn’t have A.A. I would be totally using, or drinking or going crazy. [Ellie]

However, the majority of the women interviewed had negative experiences in relation to drug treatment based on the disease model, which is used in the A.A. philosophy. Rigid policy and inhumane practices left many of the women sceptical of the overall benefit of drug treatment. One woman noted that her time in drug treatment was similar to "being in jail" [Cathy]. Another woman stated that:

I think the way treatment was set up here, and still today, is horrible. [Hope]

Residential drug treatment is one option for drug users, and many women who are mothers are directed to residential drug treatment centres as a requirement for receiving access to
their children following child apprehension by the Ministry of Social Services. The women interviewed described residential drug treatment:

Treatment was very dehumanizing. There was no understanding of the issues involved. Everyone was treated the same. I was in Maple Ridge, Brannon Lake. Brannon Lake was a boot camp. What a joke. But most of all it was completely ineffective for me and actually harmful. It’s difficult to be treated like a criminal, like a child too, when you’re not...This whole concept of tough love and behavioural modification is such bullshit. People’s needs are very different, and people’s motivations and actions are different. There is no such thing as tough love. Love has to do with acceptance, not coercive confrontation. [Hope]

All of those programs...they’re so precarious most of the time and if you fuck up once you’re out. Even if you don’t fuck up, if your attitude is not right. If they don’t like...your idea for your future lifestyle. You know, if they don’t like your schooling program or whatever it is. If it doesn’t fit into their rigid idea of what is normal, then they withdraw the support. Or they totally go out of their way to get you arrested or get you...you know, fucked up with the law or back in prison or stuff. And just undermining whatever efforts that you are making. They may not be a hundred percent efforts. Maybe you are still struggling with yourself to really...really do this a hundred percent, but...I think that as long as you are struggling to any degree, you deserve the sanctuary to do it in. [Pat]

For many of the women, being away from their family and friends was especially difficult. Many drug treatment programs discourage participants from associating with their family. One native mother stated:

The counsellors...I didn’t get off with her at all...you know, but I opened up to her...She told me, "Oh well, you can’t go to your house." And I said, "What do you mean I can’t go to my house." And she said, "Well you have free time this weekend but you’re not allowed to go to your house, cause
it's a high risk area, you don't know if your boyfriend is gonna be there." [Cathy]

Although family and friends are perceived by workers as risk factors for participants in drug treatment, families and friends can offer support which is beneficial (Taylor, 1993). Many ex-users have been able to maintain contact with their families and friends regardless of their continued drug use.

One professional woman from a working class background stated:

Many of the members of my family have problems with addiction and drug dependence. I'm sure this is quite common. At first, because all of the counsellors and drug treatment and books on addiction state that you have to stay away from this dysfunctional system, I distanced myself from my family. But, you know, this was a huge mistake. My family may have addiction problems, but they are my family and I love them, too. So now I see them. I negotiate and renegotiate with myself how much. And if I feel unsafe about my own sobriety, well I know how to take care of that now without feeling like I have to banish my family from my life. It's a terrible thing to tell people they can't be with their family or friends. What a lonely alienating thing to do to people. Just when you need support, they take it from you. It's such a straight white middle-class conception to think that you can just cut your family off like that. [Hope]

The women who participated in residential drug treatment were often separated from their own children, as well from other family members. Few residential drug programs have facilities for children, and as Rosenbaum and Murphy (1987) note, mothers are reluctant to leave their children behind. Many women have no one to care for their children while they are in residential treatment. Many of the mothers discussed how social workers forced them to enter drug treatment and to stay in it when they wished to leave. When mothers have no
child-care options while they attend drug treatment, children become temporary wards of the court if they are placed voluntarily in foster care. As discussed by Taylor (1993), many mothers believed that if they did not complete their drug treatment program successfully their children would be taken from them permanently. One mother who is currently a full-time student stated:

I felt that I needed help and I went to social services and they recommended me to a place downtown, I think it was on Hastings. And they said, I could go, they'd get me into a place right away. And I would stay there for three weeks and go on a methadone withdrawal. And that was all part of it and they took my son into a foster care home. And then I went and as soon as I got there they told me there wasn't going to be any methadone withdrawal, it was gonna be, you know, a cold turkey withdrawal. And this was after they already had my child, and there was nothing I could do. You know, I couldn't just go home. The only thing they did was help me with the child care so I could deal with the problems I was having. But I wasn't comfortable with that because they basically tricked me into doing that. I thought that was bizarre and I was real angry. [Morgan]

When mothers have a history of drug use, or if their infant is labelled NAS at birth, they may be forced or coerced into treatment in order to gain access to their infants. Several mothers on social assistance described their admittance to drug treatment after the birth of their children:

Yeah, about two days after my son was born I was bounced to detox. It was my decision, but I didn't really want to. I had to because the social services was getting involved with it, with him. They were trying to apprehend him....And I didn't see him for about ten days after that. [Lori]
Actually, when I got out of Grace Hospital I was going to stay in Homestead because I was going into their program. But they kicked me out because they said that I needed to leave my baby where he was and just focus on their program. And they said that because their program wasn't a priority over my son, that I would have to leave. I said to them, "Are you serious? After being told my son could have a seizure and do all this stuff, you expect me to forget about that and focus on this program?" And that was expected. [Greta]

Drug treatment was difficult for some of the mothers who were able to bring their children, for they were restricted in caring for them. The drug treatment program was deemed by drug workers to be more important than the infant. Mothers were not able to care for their children as they felt necessary. One native mother noted:

I didn't like it because they wouldn't let me breast feed either. That pissed me right off....They wouldn't let me breast feed and I had to get the doctor to phone and by that time he was already using formula. The only time he cried was when he was hungry right. Well um, they had, they had a special agency where they came in, these ladies, and watched the kids. They didn't allow it, right. But now they do because I just couldn't stop breast feeding in the middle of everything and that's what I would have had to do. Because you can't be late for class, because you earn like three demerits. Yeah, yeah if you were even like three minutes late, because I was feeding my kid, you know. You get demerits.

So I ended up being on reflections for almost the whole time I was there....Reflections means you're not allowed to make any phone calls. You're not allowed to receive any phone calls; you're not allowed to leave there....I spent a lot of time on reflections. It sort of defeated itself in a way, too, because I felt like I couldn't share totally of myself. 'Cause some of the things I didn't agree with. I just, I just knew I had to use a lot of "I" statements because that's what they like to hear, and ah....Well I never read whole studies but, you know, like, "I am feeling angry because, you know".
You know you had to express your anger in certain ways. [Cathy]

The mothers' wish to care for their children often led to conflict with staff, and consequently their experiences of residential drug treatment was negative and often incomplete, for many of the mothers were unable to finish the program.

In addition to conflicts regarding mothering, many of the mothers experienced religious and racial conflicts while in treatment:

> Not many native women in there to begin with. And they really pushed on the God thing too. They say they don't but they do. They have Bible study and you had to go to church. [Cathy]

During the interview period Vancouver had only two residential drug treatment centres that would accept children. As of fall, 1995, there are no residential treatment centres in Vancouver that will accept children. In the Lower Mainland, only one residential treatment centre (in Abbotsford) will accept mothers and children and it has a lengthy waiting list. Mothers have limited options for treatment and limited chances of regaining access and custody of their children. Private drug treatment is not a viable for poor women, and long waiting lists exist for the few government-funded treatment centres available to them.

One mother from an upper-middle-class background described how detox occurred in her family:

> I think the other thing that is important when we look at class differences...There was detoxing that happened in our house...a chronic detoxing. But I didn't understand...it was never defined to me as
such, because we didn’t have to take that person and put them into the Salvation Army detox, or what have you. My family would put them in the basement...They would go through detoxing in our basement but we were forbidden to go down there and they never came up and took food with us, and I knew that there was some mysterious thing going on in the basement...And it was such a bizarre thing. But it was never ever talked about in its true name...so it was never talked about. This person is down in the basement withdrawing and having DTs from alcoholism. Never, never would that stuff be discussed. [Debbie]

Options available to mothers who use drugs are limited through differential access to drug treatment and social and economic support, and the stigma attached to poor mothers who are identified by social services as known drug users. Once a woman enters a drug treatment centre, social services become aware of her drug use either through the initial approval or later through medical reimbursement. One professional woman described her past encounters with social services after she attended Maple Ridge, a residential drug treatment program:

I found that social services treated me really harshly....They knew, you know, [that she had been in drug treatment] it was on my file. Other people got a bus pass but I didn’t....they had all that information [about drug treatment], it was right there. And the thing is, the woman I was seeing was talking about it more than she was talking about anything else. [Gloria]

Although many social workers insist on drug treatment for their female clients (Cair, 1994), the stigma attached to this action makes it difficult for women once they complete the program. Upon entering a drug treatment program, poor women who have been able to conceal their illicit drug use from social services are subsequently identified and stigmatized.
II. METHADONE: A MAINTENANCE PROGRAM

Not all illicit drug users enter drug treatment in order to withdraw or abstain from drugs. A minority of long-term users opt for maintenance programs. In British Columbia, methadone maintenance is one option for users who have become addicted to opiate derivatives. Patients are only eligible for methadone maintenance after they have proved that other drug treatment has failed, that they have been addicts for many years and that they will comply with the rules responsibly (Alexander, Beyerstein, & MacInnes, 1987). Methadone maintenance allows legal, unadulterated, orally administered methadone to be prescribed to some people addicted to narcotics. It has been demonstrated that methadone maintenance allows people to lead a normal life, rather than a criminal life (Alexander, 1990; Alexander et al., 1987; Brecher et al., 1972; Dole & Nyswander, 1965; Wijngaart, 1991). In addition, oral methadone maintenance allows people to stop using needles, which reduces the incidence of infections such as hepatitis and HIV.

The methadone program in B.C. has been controversial and subject to Ministry of Health policy changes since its establishment in 1963. When methadone maintenance in B.C. was first established it was described by the Narcotic Foundation as a lifetime program for patients. Unfortunately, the early promises of the Narcotic Foundation were never carried out and methadone maintenance is not a secure lifetime program.
Rather, methadone patients in B.C. are often subject to cruel experimentation, regulation and drastic shifts in policy.

Currently, both private doctors and government clinics provide prescriptions to patients. All methadone patients must be federally approved and registered in order to receive methadone, and physicians must be federally licensed to prescribe it. Both private doctors and government clinics are regulated by the Federal Bureau of Dangerous Drugs, the B.C. Medical Association and the police (Alexander, 1990).

The B.C. Ministry of Health has regularly tried to limit the practice of private physicians in relation to prescribing methadone. The Ministry claims that private physicians overprescribe and profit from prescribing methadone, and that legal methadone is diverted and sold on the street (Alexander et al., 1987). However, Alexander, Beyerstein and MacInnes (1987) state that there are no data to support the Ministry's claims.

Drug testing and daily pick-up of methadone prescriptions is routine, though in the past some private doctors in B.C. have allowed their older more stable methadone patients to pick up less often. Although methadone maintenance offers a break from the illegal activities associated with illicit drug use and the possibility of a more stable and normal life, most drug users perceive it as a last resort:

Oh shit! I did everything in God’s green earth to avoid going on methadone. I did not want my name in Ottawa. [Theresa]
I don't think people want to go on methadone, because, number one, they know they're going to be given a low dosage number two, the pressure now is to get off methadone. There's so much pressure to lower your dosage and get off it. And it's harder to get off of than heroin, so you get a street addict who's getting high-quality, low-cost heroin and... first of all, most people don't want to go on methadone. It's like admitting defeat to yourself. You really are. You're saying, "Look, I've tried to quit... I can't quit, I can't beat it".... I don't care who they are, nobody likes to do that. And then you get a program that's got rules that basically penalize people for going on methadone. [Linda]

Twenty-five percent of the women interviewed were on legal methadone, and 36 percent had been on methadone maintenance and methadone withdrawal programs in the past (see Table 9-2).

<table>
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<th>Table 9-2</th>
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<tbody>
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<td>Legal Methadone Use</td>
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<table>
<thead>
<tr>
<th>Total women: 28</th>
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<tr>
<td>Legal Methadone</td>
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<tbody>
<tr>
<td>11</td>
<td>39.</td>
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<tr>
<td>On legal methadone at the time of the interview</td>
<td>7</td>
</tr>
<tr>
<td>On legal methadone in the past</td>
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All of the women who had been on methadone maintenance stated that methadone was a much harsher drug than heroin in terms of short-and long-term effects and longer withdrawal period:

The only alternative people are given is methadone and methadone is a really tough one because that is like the hardest habit to kick. God only knows what it does because it's not organic. Your bones, ugh.... They wouldn't legalize something more natural for your body or easier to withdraw from. It's got to be this thing that is so heavy duty.
Poison. It was invented by the Nazis...we owe it all to the Nazi scientists.[Gloria]

Like the methadone patients studied by Rosenbaum and Murphy (1987) in the San Francisco Bay Area, the women interviewed expressed a dislike for the effects of methadone and worried about the harm it could cause them long term. In addition, many researchers have noted that drug treatment services fail to address the needs of women (Addiction Research Foundation, 1994; Ashbrook & Solley, 1979; Bepko, 1991; Etorre, 1992; Kasl, 1992; MacKinnon, 1978; Mondanaro, 1989; Reed, 1987; Rosenbaum, 1981; Rosenbaum & Murphy, 1987; Taylor, 1993)

The Program

Becoming a patient on methadone maintenance requires strict adherence to many rules, and not every narcotics user is accepted. Illicit drug users who cannot show needle marks are rarely considered for methadone treatment programs. One long-term legal methadone patient noted:

Now, there was somebody who was addicted to smoking heroin, they tried to get on methadone, they couldn’t get off and they’re dead now. They couldn’t get on the program ‘cause they had no needle marks.[Linda]

Needle marks, long-term addiction, several drug treatment attempts, and compliance and responsibility are the usual requirements for entering a treatment program. Patients are regularly tested for drugs that are not approved and legally prescribed by their methadone physician. They must provide urine samples, and urine screening is often supervised by a staff member. To be explicit, this means that patients must
urinate on demand, in full view of a drug worker. One professional woman stated:

When I was in treatment it was very similar to jail. You were denied privileges. You had to pee every day in front of a worker who was just like a guard. If you couldn't pee you didn't get your methadone. And I couldn't pee with this person staring at me, so it was a real problem. [Hope]

Expulsion from the program follows if a patient is unable to provide a urine sample or continues to show dirty screens (meaning that the urine test is positive for drugs other than methadone) or is unable to follow the many other rules. Pick-up times for prescriptions and counselling are often rigid, and maximum daily doses in British Columbia are 80 mg of methadone (Alexander et al., 1987). Private doctors appear to be more flexible with their patients than clinic doctors; however, this is not consistent.

One woman currently on welfare assistance described her early encounter with the Narcotic Foundation when methadone maintenance was perceived as a lifetime program for patients:

I went into the Narcotic Foundation, spoke to the doctor. In those years they really encouraged you to go on methadone, and they sat you down and said, "Look you've tried this several times, you've tried withdrawal, this is methadone maintenance. In all probability it's a lifetime program. But we believe that there's certain people that the program will help, and obviously, you know, you're in that category. So give it a try." So, I went on it. [Linda]

Some of the long-term methadone patients spoke about their experiences in relation to diminishing methadone doses, trust and the effectiveness of the current methadone program:
I recall a doctor asking me, could I still feel my fixes, because the idea in methadone maintenance was to block heroin. Now, unfortunately they’ve got away from this idea in the last few years and this has really affected...you know, how the program works. Anyway, I was on, I think, 140 milligrams....Anyway in the last couple of years, now they’ve made a maximum of 80 and at the same time while they’ve diminished the dosage and coupled with the fact that there’s high-quality heroin on the street...I see people that have done well on methadone quitting the program. [Linda]

Oh, God. There is so much, you know, that I could say. All the years that I’ve been on the program and all the changes that they have thrown at us....they talked about trust and they lied to us. But, we never lied to the extent that they lied to us. I mean, to the point of where we were guinea pigs....I mean, what they were doing, was testing our...what do you call it, our points...to what point...how far could they push us until we, you know, got angry. You know, how far could they go...you know? Like...I was on 80 mg....how far can they push me down before I would react and what kind of reaction could they get from me? [Evelyn]

The original methadone programs envisioned by Dole and Noorlander in the 1960s advocated methadone doses that were high enough to block the heroin effect and withdrawal symptoms (Dole, 1987). The Ministry of Health guidelines dictate a maximum of 80 milligrams of methadone daily which is too low for many patients.

The structure of methadone programs, whether they take place in clinics or are run by private doctors (following guidelines by the Ministry of Health), hinder patient compliance. One woman described her initial visit to the methadone clinic in Vancouver in 1980 when she was on welfare:

I was so sick, because usually when you decide to go on methadone, you are pretty desperate. This doctor, he keeps asking me how I made my money to
buy drugs, during my visit with him to see if I was eligible for the program. I told him I sold drugs. But he keeps insisting, "Well, how do you really make your money?" Finally, I realize he is implying that I am prostituting, and finally I realize if I don't just agree this is what I do, I'm probably not going to get on the program. Because you see he had a set idea of who I was, and by trying to state otherwise I appeared to be lying and not complying with the program. So I just let him think what he wanted to because I needed to get on the program. But, you know, I only lasted about four weeks because I couldn't follow all the rules. [Hope]

Many of the women interviewed described how they were stereotyped as "bad" women, and treated as less than their male counterparts. The sexism they encountered and the humiliation they experienced in complying with many of the rules deterred many women from staying on the program. The rules often made living a normal life difficult for the women on methadone. Another professional woman described her experience at a methadone clinic:

Well, the methadone clinic in X, as far as I am concerned, is a nightmare from hell. It is just....There is nothing good about the program. The only good thing is that you are...you get methadone, So uh...you are allowed to carry on your life, but no...the way that people are treated, is...you are treated like objects....Ok, you have to go there every day between 7 and 10 [a.m.]. I didn't even mind that so much when I am in town. Then you have to go to a group meeting between 8:30 and 10:00 on Tuesday or Thursday morning. It didn't matter if you were working or what, you had to be there. And...you were allowed to have one four-day carry every three months only, so that is four times a year. They had to be every three months. I said that it wouldn't even be so bad if it was four a year and you could choose when you needed them, no.

So, ultimately, it made it impossible for me to live a normal life. My parents are older, living in X. I like to visit them. Never mind any other holidays. Then in my employment. I was requested to
go to work shops and stuff outside of the city and I wasn’t allowed to do it, unless of course it fell within the three-month period of time. If I had to teach class at 8:30 in the morning, too bad. I mean I was expected to miss it to go to this group meeting which was just a joke to begin with. [Diane]

Although most of the clinics insist on daily pick-up, some private physicians have allowed patients to come less often. One woman who was a full-time student described her experience with a private doctor:

It is...I mean now, it is three days a week. How in God’s name am I going to go to anything but university when I have to get somewhere three days a week? Yes, I have to give a urine sample, almost daily. . . . [Now] I go to my doctor’s once a week, but his is not a clinic setting. I’m his only patient as far as I know. I go there and then twice a week I pick up the methadone, so that is...he considers that to be...that works out to three times a week. Right now, that is about the average I go, about three times a week. Is that what you found? [Theresa]

The wide range of policy, from daily pick-up and supervised drug testing to pick-up three times a week and unsupervised drug testing often appears arbitrary. There were no rewards for compliance and successful long-term maintenance. Long-term patients were treated the same as newcomers. The women noted:

Well, the sad thing is...it is not even 20 years...I mean the people that have been on for 20 years, and I know people that have been on...they have just as hard a time now, as if they were brand new addicts....They have to leave all these urine samples the same as everybody else. It is awful. It is just totally awful. You know, the situation. [Theresa]

I can relate to a little bit of rigidity at the beginning, when people come on. I can relate to that. But, it doesn’t change. No matter how long
you are there and no matter how long you behave, it
doesn't matter, you are treated the same. It
interferes with your employment, they make it
impossible for you to live a normal life.
Absolutely impossible. [Diane]

Maintaining a normal lifestyle was difficult, given the
rigid structure of methadone maintenance, and the women found
the rules humiliating. One middle-class woman in her late
forties described being subjected to body searches at the
methadone clinic she now attends outside of P.C., and the
humiliation she experiences now in contrast to earlier
treatment by a private doctor in Vancouver:

Oh, yes. Every day you have to go in there and you
have to...you are subjected to body searches. The
nurses, I guess...they are a lot younger than me,
they are 20 years younger than me. I find it
very...I find them condescending. I just find it's
very undignified. For a woman of my age and because
I am a proud woman. I find the whole process
undignified. And, and...I just find it hard to even
talk about it, Susan, because all of a sudden I
feel I'm gonna burst into tears. I hate the whole
indignity of it. I just hate it. But, I keep trying
to say to myself to pretend it is insulin that you
are going to get. Pretend it is insulin. But, it
isn't and I know in my mind that [it] isn't that.
It is just very undignified the way you're treated
like a kid. Like a juvenile delinquent. When I was
in Vancouver, it never used to hurt me as much.
Whether it has something to do with my age
difference, but it just didn't torment me
emotionally as much going in once a week. [Judy]

Being able to pick up methadone once a week allowed the
women to stabilize, to maintain jobs, and to centre on other
activities other than their addiction to methadone. Fewer
pick-ups a week also allowed the women to escape the
implementation of humiliating rules attached to obtaining
their methadone. The women believed that the rules they had to
follow while on methadone maintenance discouraged stability. They explained:

You just can't work and it makes it really difficult. In other words, all the...they've implemented rules that basically, to me they're saying, well, we'll give you methadone but we're going to make your lifestyle inconvenient, we're going to discourage you so you get off methadone...and it's not realistic.[Linda]

When I was on...a methadone program and having to go every day and go to the bathroom with the door open and drink my little methadone there and never be able to take a holiday and never be able to carry for even two or three days to get away, like normal people....they encourage you to stay in the same rut that you are in.[Carol]

As early as 1981 Rosenbaum noted that social control was an aspect of methadone programs. Although the woman interviewed on methadone maintenance were hoping to normalize their life and to participate in other activities unrelated to their narcotic addiction, the rigid structure of most methadone maintenance programs made this impossible.

Overall, rigid treatment programs can be harmful to patients, and expensive. There is substantial evidence that compulsory counselling, rigidity and drug testing are not effective, and have no positive effect either for the patient or for program success (Alexander, 1990; Alexander et al., 1987; Noorlander, 1987; Wijngaart, 1991). In the Netherlands, drug testing is discouraged and methadone patients are allowed to top up their methadone with other drugs (Wijngaart, 1991). The goal of "methadone maintenance care" in the Netherlands is harm reduction. Offering education and prevention to drug
users takes priority over punitive rules that may discourage narcotics users from entering programs (Wijngaart, 1991).

The women interviewed also felt restricted in their search for a doctor to prescribe methadone. One low-income woman explained:

I actually would like to look for another doctor, because...he doesn't like us and he is very obvious about that too. He has got all these little punishment things. You know, if you can't...if you can't give a sample [urine sample] when he asks for it, he takes 10 milligrams off your prescription. [Evelyn]

Very few private doctors are federally licensed and government clinics are usually more repressive than programs run by private physicians. When women and men are unable to urinate on demand for drug testing, they are punished by having their methadone dosage lowered.

The women interviewed described the sexist attitude of many of the doctors who prescribed methadone. One woman noted how she was continually ignored by doctors during her 20 years on methadone. Instead of speaking to her directly, the doctor always addressed her husband, D.:

When they would call us in, and that was a private doctor, if they wanted to tell us about a mandate, "Oh D., will you come here for a minute?" Never once did they speak to me. Together with D., or if D. was in the washroom, it would be, "Where's D.?" Blatant, blatant, blatant. Of all the years, of almost 25 years of being on methadone. [Marg]

Because many of the doctors who prescribed methadone held sexist attitudes about the proper role of women, as Reed
(1987) notes, it is difficult for women to communicate their needs to doctors and treatment staff.

Other women noted that some doctors were uneducated about methadone and the women suffered when they had health problems (Rosenbaum & Murphy, 1987). One common misconception doctors had was that the women did not experience pain when they were on methadone. This has serious consequences, especially during labour and birth. One woman in her early fifties stated:

Too often you go into a doctor, "Oh you’re on methadone, you shouldn’t feel any pain." I mean, it’s so ridiculous. [Linda]

Although the majority of the women who had participated in methadone programs were negative about their experience, those few who were able to find less rigid private physicians were optimistic about the changes that had occurred in their lives and the opportunities for employment and stability that were now available to them. One middle-class woman described her difficulty dealing with the drug scene and the criminal overtones that government clinics promote:

Another thing is that you are...when you are down in the God damn clinics, you are constantly subjected to people who aren’t necessarily in the same space that you are. They love to talk about it, that’s their life. It is their lover. It is their companion, drugs are. If you are trying to get away from that, it is really hard, because of course, sometimes, who you hang out with, you become one of. So, when everybody is talking drugs and criminal, you end up being the same. Where if you pop in once a week, you’re in and out of there....Like in Vancouver, I was there for what...seven years and I went to the same doctor. I never got to know one patient. Not one, because...I was in and out. [Judy]
In contrast to the clinic experience, another middle-class woman described her experience with a private doctor as more beneficial to stability:

If you go to the doctor once a week or twice a week...that doesn't become the focal point of your life any more. Your life moves on to other things. You are not kept in that...that little world of, sort of, that underworld. You move out from there. I am highly successful now and part of it is because I got on a methadone program, got on with a doctor who...had more of a philosophy,...from the European nation, that...I was not a criminal. This was more of a medical problem and that it would be treated as a medical problem. And that I was a person that was not stupid and could make decisions for myself...my husband and I are perfect examples of how much better we have done, since we have been allowed to do that.[Carol]

The women interviewed were very adamant that drug use and addiction were not a criminal problem. However, as long as specific drugs were criminalized, one professional woman concluded:

Well, I think as long as it is against the law, illegal...I think that private doctors are really the only answer, unless clinics were run in a different way than they are now.[Diane]

Given the current legal status of their drugs of choice, the women favoured a medical model, in consultation with private doctors.

The women, especially long term methadone patients, were informed about the many controversies surrounding private physicians prescribing methadone in B.C. One low-income woman stated:

I...think that physicians who prescribe to users are definitely seen as drug pushers. Y'know, I think that other doctors, even when they've read
literature, have absolutely no understanding of the whole complexity of what that's all about and they perceive them as these drug pushers and really do pressure them to lower [dosages] and to have few patients. If they see them getting a lot of patients they start thinking all these weird things, like, oh yeah, easy to come in and give them a prescription and they can bill...they just have no idea how complex it is.[Linda]

**Methadone and Alternatives**

Many of the women offered suggestions for methadone maintenance reform. Several women noted that methadone maintenance programs were inflexible, for patients had to take their methadone every day regardless of need. One professional woman stated:

All the methadone treatment places you get your drug every day. So there is no support for the occasional user, the Sunday user. Most users are concerned with the supply of their drug. Where will it come from next? Will there be enough? Will it be available to me if I quit? It keeps people on the program because there is no experimenting, not on the client, but allowing them to try using once a week, twice a week, going up to every day when they want to, or down to once a week again with no penalty attached. Or someone who feels they could stabilize at a few heroin cigarettes every Sunday. I think if I had a choice, it's difficult to say this because we don't have a choice. But I would be, as an older person, happier to have that available to me, occasional use of drugs like opium and heroin. I don't use at all, because I don't want to reenter that illegal scene or place myself in jeopardy of AIDS, or hep, abscesses, all those things that the black market fosters....I think a lot of people stay on maintenance because they're afraid that if they cut back, or suggest less methadone a day, the treatment centre or doctor will see it as a failure if they ask for more. Or will just deny them access to more. So it creates this constant anxiety for users going into treatment. It's an all-or-nothing situation. And that is unrealistic and creates longing, anxiety, and eventually leads to increased use.[Hope]
The current practice of only daily maintenance options was perceived as contributing to further addiction rather than experimentation with occasional drug use and shifts in use.

Another common suggestion by the women interviewed was the use of methadone patients on decision making boards that would guide methadone programs and Ministry decisions. One long-term methadone patient stated:

Well, one change is that they have to...they have to get somebody in there that, you know, who is not biased. You know, the whole committee...who sets up the regulations and everything...they have got people in there who do not like the program...don't believe in the program, they don't like it, they wish, you know, it didn't exist. These are the people who are supposed to be on our side, kind of. Like they are supposed to be there to kind of help us. Of course they are not helping us....what I would like to see is...more input from...like with R. or B., and M., myself, you know, some input into this committee so that we can say, you know, look...we don't feel that is right, but we are not asked a thing. You know, out of all the knowledge that I think that I have...which has been a lot of years. You know, I think that I could contribute a lot of information.[Evelyn]

Many of the women interviewed felt that their experience as long-term methadone patients would be useful, and would contribute to more efficient and humane programs. McDermott and McBride (1993) discuss how successful coalitions between drug users and drug workers can be. The women noted that drug testing, monitoring and daily visits are expensive. Although they stated that not all drug users will stabilize, they felt the majority would, given the opportunity:

I'd like to see users treated as mature adults. No piss tests, no penalties, no dogma, no new religion that you have to adopt. I think professionals in
treatment are more fucked up than their clients. Though I’m not 100 percent sure about reformed addicts, some of them are as bad. But I’d like to see treatment as user-friendly, with ex-addicts and addicts on the board so things don’t get out of hand. If people feel they need treatment.[Hope]

One woman noted that it would be beneficial to include methadone patients on boards for often many of the narcotic users were aware of who the long term users were. One long-term methadone patient stated that this would eliminate new users from being admitted to the program when other options had not been tried:

But, I think that in terms of clinics that, that clinics should have boards which have addicts on them, even addicts that are presently using the clinic and that they should be involved with the other people who are running the clinic....One of the reasons that a lot of the wrong people got on methadone, because all of the addicts knew who this person was and that they should not be getting methadone. But, the people that are running didn’t because they didn’t have any experience in that area.[Carol]

III. DRUG USE, WITHDRAWAL, AND CESSION

Drug Withdrawal

Although some long term illicit drug users, and especially narcotics users, opted for methadone maintenance, many had tried to withdraw completely from drug use several times. Some of the women interviewed were successful in withdrawing and remaining abstinent; others have used occasionally since withdrawing. Some were unable to stop using. Almost all of the woman had withdrawn from drugs at home. Some of these attempts were more successful than others.
The women noted that withdrawal at a drug treatment centre was not always a viable option:

No, I just did it on my own. I’ve never been to treatment. [Sue]

No, I always did it myself. [Marg]

I didn’t use any of that. I have no idea. It never seems all that effective to me. [Janet]

Withdrawing from heroin is less difficult than withdrawing from methadone, and many of the woman felt that they lost their autonomy when trying to withdraw from methadone. Withdrawing as a methadone patient often meant that the physician rather than the woman, controlled the dose.

Several women described methadone withdrawal:

I wanted to be told, I wanted control of my destiny. I mean, I am not a kid here. It was...another part of the whole humiliating process. I said, "Look, I am a middle-aged woman. I want control of my own destiny, I want to know what doses that I am on." Well, they say, "Why does it mean anything to you?" [Judy]

It took me a month to decide to do it, because I went through the workers and I said, "Look, this is my withdrawal, you know. When I say drop me, I want you to drop me five, but I want to be able to do it on my own time at my own speed. You know, if I don’t feel like having a drop in a month, then so be it." I says, "Maybe in two weeks I will take two drops, you know." So, it was...you know, I really had to get reassured from them, because they did some...you know, they were fooling around with our lives so badly, at that point, well you couldn’t trust them. They talk about trust, you know. It turned out that I was going along fine...I knew what five felt like. When I dropped five, you know, I knew what it felt like. And I was working, so I knew a lot of the times...when I was looking at the clock at 3 o’clock, wanting to get my methadone, that was odd for me.

So, I knew something was wrong. So, I says, "You didn’t drop me five," I say, "You dropped me
ten, that is what it feels like." She says, "No, no, we didn’t." She says, "Well, I will check." She comes back and says that they did by mistake drop me to ten. You know, I still don’t know whether to believe anything they said at that point. It was like that they were still fooling around with me. Here I am taking my own withdrawal. I am coming off, what more did they want? You know, they had to fool around with that, they couldn’t leave well enough alone. [Evelyn]

The women interviewed claimed that their subjective experience of their own withdrawal was ignored by doctors and drug workers. Rather than respecting their requests, drug workers and doctors were perceived as playing games with the women when they were vulnerable and in need of support.

Another problem for long-term methadone patients was the unavailability of detox centres that would help them withdraw from other drugs. Some of the women on methadone were taking Valiums, and though they wished to withdraw, there appeared to be no options available to them:

Like I tried to get into detox because of Valium. I was on Valium and I tried to get off Valium. There was not one place that would take me, because I was on methadone. I could not go and get off the Valium, but stay on my methadone program. Not one place. [Evelyn]

Like the women on methadone studied by Rosenbaum and Murphy’s (1987), the women on methadone in this study faced many health-and drug-related problems that are not being dealt with effectively within current drug programs.

Ceasing Drug Use

Research suggests that many people are able to cease using drugs without the aid of drug treatment services
(Alexander, 1990; Biernaki, 1986; Blackwell, 1983; Erickson et al., 1987; Matthews, 1995; Peele and Brodsky, 1991; Reinarman, 1978; Stevenson et al., 1956; Waldorf et al., 1991; Winick, 1962). Many of the women interviewed had ceased their drug use prior to this study, and others had ceased drug use for long periods of time before beginning to use drugs again. As mentioned above, many were able to cease their illicit drug use without the aid of drug treatment programs. Some of the women interviewed stated that they continued to use illicit drugs and legal methadone because the drugs made them feel "normal". The term 'normal' was used, to describe a feeling of belonging and comfortableness with oneself and one's surroundings. Some of the women noted that they had never felt normal prior to using drugs. Others wished to regain the state of normalcy that they had experienced prior to their drug use.

Similar to Alexander's (1990) adaptive model of drug use (see Chapter two), several women described how the use of illicit drugs made them feel normal:

You know, and of course when you are young, you know. People notice different kids....I was never happy. I couldn't understand how people could smile and make jokes. I mean, the world was going to blow up, there are people starving, there is...and all of it would get to me every day. I would remember this all the time. The first time that I ever got relief...any true relief, was when I started doing heroin. It was almost like it put that extra skin on me that most people have so that they can deal with the world. And laugh and have a good time and enjoy a beautiful day. I couldn't do that. I never could, without heroin and I don't know why, to this day. I don't know why.[Theresa]
I don’t know, people assume you’re high, but most people who use narcotics just feel normal when they use. For me, I didn’t feel normal unless I was using. So my quest was normalcy, not the high. [Hope]

One woman attending full-time university described how she felt normal prior to using drugs:

I felt like, before I did drugs I felt like I was normal. Even though I had been drinking beer I felt really normal...I felt that, yeah, that I could fit into some pattern. I didn’t feel totally ostracized the way I did after I used drugs. That’s what I meant by normal, in the sense of how I felt after I used drugs, in the sense there must be something terribly wrong with me because, you know, I did this. [Morgan]

Others tried to recapture that sense of normalcy after they ceased using drugs:

But what a nice dream to go back to being somewhat happy and normal again. [Pat]

I enjoy doing other things, you know. I used to say before, oh I wish I was normal, [laughter] you know, and, you know, now I am normal. And I enjoy it. And I made a point of wanting to be normal. [Sue]

As Weil and Rosen (1993) noted in their interviews with drug users, the pursuit of feeling "normal" appears to be a defining factor both in continuing drug use and in ceasing drug use.

In Chapter six, the lifestyle that many of the women were exposed to was discussed. For some of the women, the lifestyle associated with illicit drug use became too wearing. One low-income woman noted:

Yeah, it is mostly the bizarre nature of the lifestyle, that I just...I couldn’t live with it any more. It was making me crazy. There is so much
ugliness there, there is so much ugliness in yourself that’s hard to deal with, and the shit that other people are doing. Just...it is just too ugly to have to live with. I mean, it was getting to the point where it is was, fuck, either kill yourself or get up and do something else. Get a gun or get over it. Because there are no other choices here. So, I got over it. [Pat]

Other women ceased their drug use after experiencing traumatic events in their lives. Two women of colour describe the situations that led them to stop using illicit drugs:

I guess what finally happened, my mum had been diagnosed with cancer of the blood about a year before this. And I guess in a lot of ways I was in a lot of denial, I couldn’t imagine living without my mom, or my child. And I tried really hard not to focus on those things and I was sitting in my apartment one night and my mom was in the hospital literally dying and my son was there. And I just couldn’t put the drugs down, get out of the house to go to the hospital to see the mom. And that’s when it really hit me that this was too big for me, way more than I could handle. So I phoned this person to get me out of the house and I went up to the hospital and I got there and I, and they said to me, mum’s sleeping very peacefully, so maybe you could just let her sleep. And I was gonna leave, and I got downstairs, and just something said to me if you don’t do something now, you’re not going to make it. And I just went up to my mum’s bed and poured my heart out to God and just pleaded, and I’ve never used since. It’s been 13 months. [Greta]

When I met someone that didn’t judge me, that accepted me the way I was and treated me as a normal person then that’s when my life started to change, you know. And from that point on, you know, I started believing that I could do it. And I was a very bad addict. I was the kind of person you thought would never leave the street. [Sue]

Another woman on social assistance stressed the need for "sanctuary" once the decision to stop illicit drug use was reached:
I think one of the most important things is to have a secure place to live. Being on this street, it is really tough to maintain a home of your own and addiction. And...I don’t think you can do it unless you have sanctuary to start with. That’s really important for it. [Pat]

Overall, the women spoke about a wide range of experiences that influenced their decisions to stop using illicit drugs. There was no one magic formula but many of the women noted that their success was due to the fact that they had stopped using illicit drugs because they themselves wanted to. One young mother of two children stated:

I think the main, main thing that I can say is, like, you can’t do it for other people....I really don’t think it is possible to do it for anybody but yourself, really. Like, not even your kids. [Mary]

The women noted that attempts to stop using illicit drugs for their children, their family or their social workers were not always effective. Furthermore, treatment is limited when compulsory. One native Indian woman stated:

To tell you the truth, I don’t think that any kind of treatment works. It has to be your own will. [Cindy]

Women are sceptical of drug treatment, for they have been forced, pressured and directed to drug treatment even when the program did not fit their needs and when abstinence was unrealistic.

Shifting Patterns of Use

Many of the women interviewed discussed their shifting patterns of illicit drug use. Many had successfully quit using
illicit drugs for long periods of time before starting to use again. One professional woman stated:

So you know, then that's the fearful thing because I quit those years and started again. And then quit for years and started...Then I'll find a reason, I'll find the strength to quit or whatever. And then after a while that reason maybe doesn't exist any more. Or I'll start using again slowly, just a little bit, just occasionally and all that...it's just been a real seesaw back and forth. [Gloria]

Defining drug use according to Alexander's (1990) "continuum of involvement" illuminates the wide range of patterns of drug use. These are rarely static, as many of the woman interviewed noted.

In addition to using illicit drugs on and off, many of the women noted that they had successfully stopped using illicit drugs, but continued to use licit drugs. One woman of European heritage explained:

I don't know if I'm ever going to completely stop taking drugs because I still smoke, although I've cut down cigarettes and I think I will quit smoking cigarettes...I still occasionally drink a few beers, but not often, but, you know, if I go out. And I'll still take painkillers if I feel that I need them. So, I think what I've done, I think, well, I'm not gonna do something crazy to get a drug. Well, I'm not gonna do that. [Morgan]

This woman was intent on leaving the criminal lifestyle associated with illicit drug use. By using only licit drugs she limited her chances of arrest, incarceration and possible separation from her children. However, limiting drug use to only licit drugs is not an option for everyone. As mentioned earlier in Chapter six, some of the women disliked alcohol.
Some of the women interviewed expressed their wish to be drug free, though at the time of the interview they had not been able to achieve their goal. One self-employed woman on methadone described how she hid her sorrow by acting arrogant:

Yes, it hurts my feelings really bad. I am ashamed of myself. I am really, really hurt inside....I can feel how arrogant that I am being about the whole thing. Because really I mask the fact that I am really upset about it. Because I would love to be drug free.[Judy]

Other women were not attempting to achieve abstinence or occasional use of drugs, for their addictive drug patterns were directly related to their desire to suppress deeper painful experiences. One low-income woman whose children have been permanently apprehended by the Ministry of Social Services stated:

I try to get all this shit out of my head. All my family problems. You know, I was raped when I was younger. Being numb. Get all the old tapes out of my head. As soon as I get my life in order, you know, some of it, you know, then I could get off the drugs and stay away from it, got clean. I have done it before on my own. Then I go back to it. I get depressed, I get depressed. I want to commit suicide....You see, with me, I won't face reality because I don't want to face reality. I don't want to face reality. Reality sucks and it hurts too much.[Julie]

For some women, addictive drug use is one way of adapting to a "dire situation" as Alexander (1990) states in his adaptive model of negative addiction.

IV. ALTERNATIVES TO CURRENT DRUG TREATMENT
During the interviews, the women discussed alternatives to current drug treatment policies and offered suggestions for reform. One woman in her early fifties noted how societal expectations are so much higher for illicit drug users than for licit drug users:

The person tries to quit smoking or to quit drinking and they fail, what do they do? They run down to the corner store, pick up their cigarettes or to the corner liquor store and pick their booze up. Now, if you try to quit heroin and you fail, it's not a matter of going to the corner store. It's a matter of going back on the street, and inevitably jail or death. And each time you quit or you try to quit and you fail, you face this, and this is to me where methadone comes in.

It's not that people want to go on methadone, it's that they get to a point in their life, they say, I've tried to quit, I can't quit. I read some [statistics] a few weeks ago that 95 percent of people that lose weight gain it back. Now, how much harder is it to quit heroin? Now, some people would say that's debateable [laughs], you know, but why...would they single out, they take the heroin addict...he's supposed to be unstable, like uh, bottom level of society...at the very bottom, and yet they have greater expectations...society in general...of this lowly heroin addict than they do of our most stable citizen. How many times have you seen people that quit...that are productive in the community and yet they...when I say they can't quit smoking, I don't care the reasons. They're still smoking. You know, they can't do it and yet society says, well, if the heroin addict can't quit use of heroin, tough. They're going to have to face the consequences, which is going on the street, you know...it's that black and white. Well, nothing in life is black or white. And I think they have to come to more real...you know, face up to reality, that most people don't quit. There are some that do, and it's wonderful. [Linda]

Drug treatment programs in Canada have been unable to face up to the fact that abstinence is an unrealistic goal for some drug users. Rather than punishing illicit drug users, it would
be more beneficial to recognize the limitations of our current drug policy.

Alexander (1990) notes that imprecise definitions and labels have led to misleading information about people who use drugs. Official drug policy has no language for different patterns of drug use outside of problematic drug use. Drug policy and drug treatment are based on an abstinence model and not all drug users are able to benefit from this model. The women discussed the harm of current drug treatment policies and how illicit drug users, rather than the method of treatment, were personally held responsible for failure:

It is all set up to make you feel like a failure, because when there is only one method of treatment, if you don't fit in there. Well, that is the reason that...one of the reasons that you became addicted in the first place. It is not like you ever fit in anywhere. So, it...just ties into the whole thing.[Linda]

But mostly I think we have to look at how the medical profession in treatment also perpetuates myths about addicts and contributes to the addict's perception of themselves as bad, immature, unable to be responsible. I think people who use drugs are responsible. Do have control. Using a drug doesn't give you a licence to behave in negative ways. When people say, "Oh I was drunk," or "That's because I was addicted," I don't buy that. That was the person being a jerk, the drug is not responsible. But I think the structure of our treatment centres makes it impossible for drug users to be honest, the laws make you feel dishonest. The things you do to get the drug, because you have to deal with the black market. So you begin to feel that is you. So instead of this focus on treatment centres, I'd like to see some recognition of how these centres can harm people, how they have become an industry. If we wanted real change in how people use drugs we should change society. Why do people want to use a drug? Why is that preferable?[Hope]
The women emphasize the ways in which current policy perpetuates myths about people who use illicit drugs. Rather than one model of drug treatment, the women interviewed asserted, many different programs should be available:

I think there should be a variety of programs because people react, y’know, differently to different programs. [Cathy]

Back to treatment, I think that whatever works for a person, whatever it is they feel will work. If the A.A. model is for them, go with it. If they want to do it alone, let them. We assume people need treatment, but I don’t think so. Most users do stop on their own, without a detox centre or treatment, or counselling. But treatment has to recognize that each person is an individual, there’s no universal answer, or answers. [Hope]

Other women discussed how the whole concept of treatment needs to change. Rather than just treatment, support of all types should be available to women:

Well, I think there should always be, you know, places for people to go to who need help. Places people can go to and get help right away to get help, when they decide to get help, not, you know, two weeks from now. A place where people can go to talk to people, but I don’t think it has to be that big of a deal as it is. I don’t think that people should go into a place and have their stuff searched. Which happened to me many times when you go into detox, even an alcohol detox I think they do it, like search you. So I mean, maybe that’s for financial reasons because they don’t want people in there wasting their time. But is the real reason for doing that, because if somebody is in there claiming they want to help themselves. The individual who is getting the help is going to determine what is the best help for them. Nobody else is the expert. There are no experts. What I’m saying is that there isn’t any experts. So if I go for help, maybe need help financially, or maybe I need a place to sleep, someone [to] help me with my children. The rest of the stuff...discussion maybe, and some new knowledge, but when you want it. [Morgan]

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The women discussed the need to establish drug treatment programs where infants could remain with their mothers. One woman who had lost custody of three of her children to the Ministry of Social Services suggested that a supervised setting could be provided for mothers and infants labelled by the Ministry as "at risk," rather than separating the infant from the mother:

A place to have some kind of drug rehab where they would put the babies and mothers together in a supervised setting. The baby wouldn't be at risk because they'd be supervised all the time. I think that would really help. It would help a lot more people than what we have now, which is nothing. [Liz]

Finally, the women interviewed discussed the need to broaden drug treatment to include maintenance programs, with other drugs available, and to stop penalizing drug users in maintenance who supplement their maintenance drug, especially under the current system. One professional woman on methadone noted how important it was to reduce harm rather than punishing drug users:

So, I think that it is really important for them to open that up...there should not be just methadone either. They should have other forms of treatment. I mean if they take heroin or morphine...you know, it should be other ways. So, what if people...it doesn't really matter if they supplement. They might supplement for awhile and still do other drugs on the side. But, there will be a time when that life just won't hold the same draw for them that it used to. For some it may be in their late 20s. Others it might be in their 30s. But, there will not be the human loss and the human misery and this revolving door, jail and losing babies and child welfare and addiction, that we have now. I mean, what have we got to lose? It's not working
the way it is. So why can't they just try something different?[Carol]

Heroin maintenance

High on the list of methadone treatment reform, and drug treatment reform in general, was the need for heroin maintenance programs. All of the women who had been on methadone (36 percent) stated that they would prefer to have legal heroin maintenance rather than the current policy of exclusive methadone maintenance programs.

I would rather have heroin. Because I think in the long run, I think that the heroin itself...it is not as bad for you as methadone...they are starting to know more about methadone, because they didn't at the time. Methadone gets right into your very bones and what not. You know, it gets...it is such a horrible thing to come off of. Heroin is nothing to come off of.[Evelyn]

I mean if you were addicted to heroin, basically it is not to switch from one drug to the other. I mean that is not the answer either. I mean, if it was heroin that you had a problem with, well, then I think it should have been dealt on that basis, with heroin. You know, I think it would be much easier and I think that in the long run, my life would have been different, if I had...either come off or stayed with the heroin, either on a treatment basis, exactly how a treatment program would go about...I don't know, but I think basically, it should have just been, be there and we should be able to obtain it. I think health wise. A lot of people, things methadone does, heroin does not do to you. I know a lot of people have a hard time thinking that way. You know, heroin, oh my gosh!!

You know, heroin is not a bad drug, you know, bad as far as side effects....methadone has a lot of side effects....you wouldn't have such a fear of coming off it. I mean methadone, you have that fear, you know. You know, you do something wrong, you go to jail, you are not going to get your methadone, I mean, the fear is always there of not being able to get your methadone one day. One day would make a difference....So when you are always, in fear of that. Heroin is much easier to come off
Because methadone is more difficult to withdraw from than heroin, many of the women discussed their fear that they might be subject to methadone withdrawal due to arrest and subsequent policy changes. The perceived health risks associated with methadone maintenance have continually been an obstacle for illicit drug users (see Rosenbaum & Murphy, 1987).

One woman discussed the official rationale for continuing methadone maintenance to the exclusion of other drugs:

The argument for methadone is so lame. That it is easier to dispense, longer acting. Why can’t I have heroin cigarettes or opium? Why would they be difficult to dispense? They give methadone because it is the least desirable narcotic....They are so worried that someone might actually like their drug, and drug treatment is not about liking what you’re given. So methadone fits the bill, a mundane, heavy drug, unlike heroin.[Morgan]

V. CONCLUSION

Although some women are able to benefit from drug treatment, a majority of the women interviewed have been subjected to inhumane and cruel treatment. The separation of mothers from their children during drug treatment is a primary injustice. The prejudice many of the women experienced from social workers after admittance to drug treatment was also a deterrent to receiving what little help is available to mothers who use illicit drugs.
All of the women interviewed rejected the criminal model of addiction. Most also rejected the disease model, which requires total abstinence. Given the current system of criminalization, the women supported a medical model of addiction, though many expressed the need to move away from this model as well. They discussed a wide range of drug policy and drug treatment options that would incorporate a harm reduction model and acceptance of drug users and drug use. They also discussed how decriminalization and legalization of drugs might allow the drug user to monitor drug use without the aid of "experts".

Methadone maintenance in Western Canada was also discussed. The women described the humiliating practices of supervised urine testing, body searches and rigid policy that rendered methadone maintenance programs a failure for both the drug user and society. Reform of current methadone maintenance policies was suggested, with an emphasis on methadone patients on policy-setting boards, including government boards that direct policy. The inclusion of legal heroin in maintenance programs was advocated by all of the women who had been on methadone programs. The availability of other forms of drugs, such as heroin cigarettes, liquid opium, etc., was also advocated.

In preference to drug treatment based on the disease model and the 12-steps approach, the women claimed that treatment must be flexible, building on the drug user's
perceptions and needs. Research that demonstrates that drug users can control their drug use and stop of their own volition suggests that the disease model and compulsory treatment are ineffective and harmful. Advocates of the disease model of addiction view medical and psychological assessment and treatment of drug users as less punitive than criminal sanctions.
CHAPTER 10 - The effects of the criminalization of "narcotics"

I. INTRODUCTION

Mothers who use illicit drugs are challenged on many fronts, for their behaviour is perceived as especially deviant by society in general, and in particular by the medical, social service and criminal justice systems (Cuskey, 1982; Humphries et al., 1992; Etorre, 1992; Greider, 1995; Maher, 1992, 1995; Maier, 1992; Paltrow, 1992; Rosenbaum et al., 1990). Mothers who come into contact with the criminal justice system due to this bias are also vulnerable to race, class and gender bias (Gómez, 1994; Griffiths & Verdun-Jones, 1989; Faith, 1993; Humphries et al., 1992, Martel, 1994; Paltrow, 1992; Rosenbaum et al., 1990). Women are subject to formal social control through the criminalization of illicit drugs.

In addition, the artificially high illegal market prices of illicit drugs ensure that most poor users must occasionally engage in other criminal activities to support their families and their drug use. Mothers whose children are in the custody of the Ministry of Social Services or of relatives, receive harsher sentencing than those whose children are in their care at the time of arrest and sentencing (Carlen, 1983; Daly, 1987; Eaton, 1985; Masson, 1992). Like medical and social services, the criminal justice system reinforces family values that are unattainable by most women in conflict with the law.

This chapter will highlight the opinions of the women interviewed in relation to drug and drug-related charges,
arrest and prison, police surveillance, prostitution, re-entry and the possibilities of decriminalization and legalization.

II. DRUG AND DRUG-RELATED CHARGES

Twenty-four (86 percent) of the women interviewed stated that Canadian narcotic laws have had negative effects on their lives. As well, 23 (82 percent) of the women have been charged with drug, and drug-related, offences. The majority (over 75 percent) of the women had spent short periods of time in jail upon arrest and sentencing for minor charges, and seven (25 percent) had been sentenced to prison for longer periods ranging from over six months to two and one half years (see Table 10-1). Five (19 percent) of the mothers interviewed lost custody of their children due to arrest and incarceration, and of those 19 percent, only one mother was able to regain custody of her child after her arrest.

Table 10-1
Drug and Drug Related Charges

<table>
<thead>
<tr>
<th>Total Women: 28</th>
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<th>%</th>
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</thead>
<tbody>
<tr>
<td>Total women with drug and drug related charges</td>
<td>23</td>
<td>82</td>
</tr>
<tr>
<td>Incarceration under 6 months in past</td>
<td>21</td>
<td>75</td>
</tr>
<tr>
<td>Incarceration over 6 months in past</td>
<td>7</td>
<td>25</td>
</tr>
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</table>

Police activity, drug and drug-related charges, the fear of arrest for themselves and family members and the stigma attached to arrest and prison time had left them sceptical of the legal system. Only four of the women interviewed claimed
the law had not affected them, although three of them had been charged with drug offences, fraud and prostitution:

I never really had any contact with the law, just when I was working downtown. I was never really in contact with the law. [Liz]

I don't think that I cared, really. I didn't think that I had much to lose. You know, I never thought of consequences, really. [Mary]

The Narcotic Control Act has had many negative consequences, direct and indirect. Many of the women had accumulated several drug and drug-related charges since they had began using illicit drugs. Often their charges were accumulated within a very short period of time:

Uhm...trafficking heroin, trafficking cocaine, possession of stolen property. Many, many, many, many counts of prostitution, quite a few counts of possession, credit card...and on and on and on. I have got a really, really big record that I put together in probably the space of four years. I have probably put together almost 20 charges. Yeah, once it starts...it just goes from there. [Pat]

Well, I had forgery when I was, like, 18,...I had a record, but I had never had a felony before, I had all misdemeanours. They were pretty small things. I had like a couple of...like, in N.Y. I had...loitering. Actually what I did last time, I didn't get busted for drugs, it was for writing cheques for money to get drugs. [Morgan]

Shoplifting, mini minors...Oh, yes, possession of marijuana, but no narcotics charges. I have about six shoplifting and one possession of marijuana and that is all. [Judy]

Yeah, for drugs and alcohol. Yeah, altogether about 10 convictions for about six, seven years. [Lori]

Arrest, drug charges and convictions were primary effects of the law. However, drug-related crime is more a result of prohibition laws than of illicit drugs causing crime (Hadaway
et al., 1991). Johnson and Rodgers (1993) note that the high rate of arrest for minor charges demonstrates how the criminal justice system has failed women, for arrest and prison have failed to divert women from further criminal activity.

Many of the mothers, low income and middle-class and professional women, spoke about how their lives were affected by the law in more indirect ways, including changes in their standard of living and their lack of legitimacy:

Well, directly the laws have taken a lot of...a lot of loved ones away, in jail. Nonviolent crimes, and we haven't hurt anybody. So, that directly affected my life. Indirectly, it makes you feel like you're not a real citizen of the country, because, you know, you don't feel legitimate, a legitimate person, because you are considered a criminal. And...I think that when people are younger, they might almost be arrogant about it to cover up their hurt and shame. They can't be...they are not real citizens, so they become sort of cocky and they hide behind [an] anti-establishment attitude. But I think that it does really hurt. Especially in your older years, when you do want to be...you want your voice to be heard...legitimate voice for your country.[Judy]

Well, yeah, I had to escape to the States. It threw my whole life off. I had almost a nervous breakdown by the end. I was stranded down there with two little kids. Their dad was in jail. Yes. It affected me.[Janet]

I feel like I have to have myself completely covered on all...Because I don't really have any rights....they are more or less privileges.[Morgan]

Oh God. Immeasurably. You know, in every which way possible. I don't imagine you want a long story on it?...It depends on the year that you are talking about. I mean, drug laws have changed over the years and it has been given different interpretations...o.k., if you want my real honest opinion. If drugs had been legal, all drugs had been legal at the time that I finished high school...I probably would be sitting in S.F.U. or
The women discussed their lack of credibility and voice in Canadian society and their vulnerability to persecution. Their status as illicit drug users had become a tool with which to silence them. For many of the older women, the recognition of their criminalized status was problematic, especially since they felt concerned about the political context of their lives, as illicit drug users. Hiding their illicit drug use from family, co-workers and society in general added to their lack of legitimacy, and made it more difficult to feel that they would be able to participate in changing their social and political environment.

During the interviews, the majority of the women responded by drawing on their own experience with the law. Only 25 percent of the women were in a stable full-time relationship at the time of the interviews. Two were widowed. However, some of the women spoke about the effects of the law in relation to themselves and their husbands:

I mean, I was married to my husband, who was an addict also. And, the fourteen years that I was with him, he did a lot of illegal things to support our habits....So, in a way, he took a lot of the...that kind of pressure off of me, but he ended up being in jail a great deal of the time. Then, during that period of time, I would be trying to supply him with drugs to keep going and to keep myself going....A lot of it was a nightmare, basically. He ended up dying in jail with an overdose. He was really talented in all kinds of
ways, but because of the laws, he ended up having...to work doing illegal things to keep our habits going. And...yes, it is just...it didn’t make it possible for either of us to do anything else with our lives.[Diane]

Oh, well, because of my husband, oh, definitely, yeah...because P. went to jail for it.[Linda]

The lack of legitimacy, the loss of husbands and partners and family members and the inability to create or sustain another way of life under the current drug legislation were evident in the women’s responses. The artificially inflated prices of the black market and the amount of time and money required to sustain their illicit drug use left little time for other more conventional and creative pursuits. The death of loved ones was a constant backdrop during the interviews. As one woman stated:

The cost is so amazing, so many people I knew growing up are dead now. You know, overdose, AIDS. It breaks my heart, because it didn’t have to be that way.[Hope]

The violence generated by the "war" on certain drugs affects not only individuals who use these drugs, but all members of society. Death is one horrific outcome of the war on drugs; others include police intervention and prison.

Fear of Arrest

As mentioned earlier, 44 percent of the women interviewed stated that they were more concerned about the drug laws than about social service intervention (see Table 10-2). Overwhelmingly, the women spoke about their fear of arrest and the consequences of arrest. Johnson and Rodgers (1993) state
that approximately 5,400 women in Canada were charged with drug offences in 1991 (p. 102).

Table 10-2
Level of concern about social service intervention and drug laws

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Total women:</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>More concerned with drug laws than social service intervention</td>
<td>12</td>
<td>44.</td>
</tr>
<tr>
<td>More concerned with social service intervention than drug laws</td>
<td>12</td>
<td>44.</td>
</tr>
<tr>
<td>Drug laws and social service intervention equal concern</td>
<td>4</td>
<td>12.</td>
</tr>
</tbody>
</table>

For the few women interviewed who had no criminal record, their sense of luck and fortune in not having been charged with a narcotic offence is evident:

Well, I’ve been fearful of being arrested. I have been involved in the criminal part of that, so I had cause to be very paranoid and nervous about it. I got through it without ever being arrested. I was really fortunate.[Greta]

No criminal record, but I’m telling you I believe in God, because there were a few times where I was ratted on.[Marg]

The rest of the women interviewed were not so fortunate. The threat of the law was often realized. The fear and destruction brought about via the law was apparent to both low income and middle-class women:

I was so afraid of the cops. I was so afraid of being busted.[Pat]
I was more worried about the law [than about social services]. The consequences of arrest seemed much more severe. [Hope]

Due to their fear of arrest, many of the women were concerned about the quantities of illicit drugs they had carried in their personal possession, or had in their homes. Some stated that they only carried or dealt in small amounts because they did not want to be sentenced to prison:

But the only thing that I worried about...I had a clean record, so, like, even if they catch me with a gram...cause I would only ever have personal use on me. You’re allowed to have so much if you’re an addict...and because it would be my first offence anyway, and I don’t traffic, I didn’t have to worry about getting charged with trafficking cause I wasn’t doing it. [Karen]

Yes, because lucky enough I never...I was always so frightened to go into jail, because I had a kid...I never did anything big time. I was nothing but a gram dealer...fortunately enough, I guess I had enough intelligence to know I couldn’t get involved in anything big that would put me in jail. Suspended sentence was all I ever got. Thank god. Because that is...I think that is really what saved me from ever going to jail. I knew that I just couldn’t. [Because of the baby]...and God knows what I would have done. Maybe I would have been a stool pigeon if it came to taking my kid away. All of those unthinkable things. The only option for me was a quarter percent, 25 percent is to get away with it. The rest of them are unthinkable, so I never did it. [Judy]

There was a lot of fear there. I think that is what...why I didn’t get into any trip too heavy, because I didn’t want to go to jail. No way. [Sarah]

Many of the women were successful in maintaining a low profile and protecting their family life by dealing small quantities of illicit drugs. Other women who transported or sold larger quantities expressed their fear of arrest due to
the fact that exporters and traffickers receive harsher sentencing, the maximum penalty being life imprisonment. One woman from a middle-class background stated:

I was a mule, I made lots and lots of money. Still, the worry, the stress, cause if you go down, you go down big. [Marg]

The women were aware that possession of large quantities of illicit drugs brought prison time. However, the chance to earn more money and to maintain a better standard of living for themselves and their children was appealing, especially when many of the women had no other monetary means outside of welfare assistance and drug dealing. Many of the white middle-class women had been dealing larger quantities of drugs than the rest of the women interviewed. For them, the narcotic laws presented a larger threat, based on their own experience of being charged with trafficking rather than simple possession. Furthermore, their association with partners who were dealing large quantities of illicit drugs and engaging in other more serious crime placed them at risk. Although these women had both economic and social resources that they could draw upon on arrest, the law was perceived as threatening.

III. ARREST AND PRISON

In 1991, women constituted about 15 percent of all adults charged under federal drug legislation in Canada (Single et al., 1994, p. 260). In 1992, 5,860 adult women were charged with drug offences (including cannabis) (Statistics Canada, 1994, pp. 2-7). In terms of pharmaceutical drug offences,
women accounted for nearly a third of convictions, though they accounted for only 10 percent of all cocaine charges (Health and Welfare Canada, 1991, p. x).

Like the Canadian cocaine users studied by Erickson et al. (1987), the women in this study initially appeared to have little regard for drug laws. Some noted that they were fairly unconcerned about the law until they actually were faced with arrest and the consequences of arrest. This did not deter them from continuing their drug use; rather, their awareness of the law became an additional burden to bear in their already marginalized lives:

Well, the thing is, when I was at the most risk with the law was when I was least concerned about it because I was really, my concern was getting high. Well, not getting sick, not really staying high, not getting sick. And I put myself in extremely dangerous positions, with extremely dangerous people. And didn't, I mean I just blocked out stuff. When I got busted I had to face up to it. After that I did it again and I put myself in some really hazardous situations with people....You are so detached from what real life is. [Gloria]

I think I was fairly cocky, and was fairly stoned and fairly arrogant at the time, so it wasn't a concern of mine until the first time I was arrested. I would have been, I don't remember, it was 14 or 15. [Debbie]

To tell the truth, like, now, I really care about things, but before I didn't. I just didn't care at that time. [Cindy]

Other women had spent lengths of time in jail when they were juveniles. For some, their fellow inmates were friends and family. One native woman stated:

I had no problems when I was in jail, actually, I actually did o.k. It flew by. I knew everybody.
They were all my street sisters. People I had worked with...That's more why I never said anything to anybody [about being underage]. Because I had all these people here, that knew my family, knew my sister, or went out with my brothers. So I felt safe.[Jane]

Not all of the women had friends and family within the confines of prison. But all were introduced to criminal activity. Two young women noted:

I probably spent at least eight months or six-seven months in jail, in juvie jail, right?[Sue]

First offence and I got probation and then I breached my probation twice, so for two breaches of probation and one offence, I got six months. That's ridiculous...a 13 year old. I learned more in jail than I ever dreamed of knowing from the street. Cause you get...that's where you get a mix of everybody. You don't get to pick who you hang out with. You're stuck in there with kids who've murdered. There was a Japanese girl in there for three years who was caught with all this heroin on her in the airport, who ended up getting killed after she got released...I learned more from them. I mean, you hear about it, you want to try it. You get more curious...[Karen]

For some women, their arrest and subsequent treatment within the criminal justice system encouraged, rather than diminished further involvement with illicit drugs. One middle-class woman discussed her past drug conviction:

It was a bundle. Twenty-five caps. Which is nothing, but to them...I just think of how...I wasn't a criminal...but, I mean, it put me on a path of no return and basically they said, at my trial and everything, you're a junkie. And I thought, you want to see a junkie, I'll give you a junkie. It was like self-fulfilling prophecy. I was just so devastated...and bought into the whole stereotype, as I say, of what a junkie is. That I just thought, well, if that's what you think I am, then I might as well be that.[Carol]
Being sentenced to prison was also problematic when the women became adults. The stigma, long sentences and the loss of family were deeply felt. Some women described the reality of prison time and the restrictive and humiliating process of criminalization. Two women from working-class backgrounds noted:

I mean, being in jail, it totally strips you of any self-worth that you have. After people handle you, and you know, put chains on your ankles, and transport you to places with shackles on your feet....with shackles on your feet, with your hands tied around your waist with a belt. And after you’re treated that way, after a while you give up a part of yourself and I think that they take it from you. And you give it up because physically, you just don’t know, mentally you don’t know any better and physically you have to. And a lot of people never get it back and a lot of people, if you expect a certain behaviour...then you will get that behaviour from them. And if you say that all drug addicts are the lowest things on earth, then that’s what they’ll be. And if you start treating all people with respect then, you know, you start seeing improvement. But as long as we have this myth about drugs and about what it is. And we have people drinking alcohol, people who work in these drug enforcement agencies that go home and drink booze and smoke cigarettes and then come out on the street the next day and bust somebody for crack or heroin. It is a double standard. [Morgan]

I got two years less a day. And that was another problem I see with the laws and the way the whole judicial system is set up. I think it would have been better for me to go to the penitentiary, where I would have had more chance to attend university, 'cause I already had my Grade 12 finished....The jail wasn’t set up for long-term people like...the average length of stay there was about a month. And I saw women come and go, like, four and five times, and that’s really hard, to be in jail and see...people are preparing to go and then they are out and then they are back....And the tension in the jail, I mean, there was a few people that as soon as they came in the whole jail was just, like,
you were always watching your back and they just terrorized everybody.[Carol]

Incarceration revealed the inadequacy of the penal system in relation to women (Faith, 1993). Few services such as education and drug treatment were available to the women in this study. As well, the social fiction dividing illicit and licit drugs was blatant. Shackling women and treating them as if they were "dangerous offenders" only exacerbated already distrustful relations between the women and the criminal justice system. Incarceration was difficult for the women; separation, and loss of children while in prison was doubly traumatic for native and non-native, low income, middle-class and professional mothers:

That meant that I was [to prison] for 17 months. And when I got out, B., L.'s dad, had L. long enough that he thought, well, we will just get her out of my life. I was an inconvenience to them then. They had done this whole thing of having the nice little nuclear family and they pretended that L. was their kid, between him and his...it was really his step mother. And step sisters. They basically changed his name. They divorced me completely from his life.[Carol]

Well, it completely affected my life, for one thing I spent time in jail for drug related crimes....They affected me a lot. With both my children, with my first child...that was when I had to go to jail, I was gone almost three years and we were separated. And I had a lot of problems with my child due to the separation. Because of the separation. And a lot of problems with myself.[Morgan]

I was arrested for possession of cocaine, the kids were apprehended. And I felt really, really upset because I thought I'd lost them for good that time.[Cathy]
I didn't even care about the going to jail, although I thought that would be pretty hard. That was a little frightening...it was the separation from the kids. [Janet]

Women who are sentenced to prison often lose custody of their children, for there are few prisons that allow children to reside with their mothers, and then only if their children are under two years of age (Faith, 1993). The majority of women who are sentenced to prison are mothers (Faith, 1993). Most of them are poor and single parents and the separation and loss of their children are of primary concern (Faith, 1993; Simpson, 1989). Women who have sole responsibility for their children feel the impact of prison more deeply than do men (Johnson & Rodgers 1993). As noted earlier, women who have their children living with them at the time of arrest and sentencing are likely to receive a more lenient sentence than those who no longer have custody of their children (Carlen, 1983; Daly, 1987; Eaton, 1985; Masson, 1992).

The criminal justice system serves to reinforce family values, and the loss of custody leads to subsequent harsher penalties. There appears to be no recognition of the extended family, and this has negative implications, especially for native Indian women in Canada. For these women, children may be raised by a member of the family, rather than by the birth mother (Monture, 1989). Twenty percent of the children born to the mothers interviewed were in the care of relatives. The decision to place a child in the care of other family members was judged by the criminal justice system as a sign of neglect.
and poor mothering. But for the birth mothers the decision to have other family members raise their children was an act of good parenting. In the case of one woman of European heritage whose drug use was escalating, her middle-class family offered a safe and familiar environment for her children, rather than a life fraught with unpredictability and possible child apprehension:

I didn’t want to do that to my kids, so I went to my family....[and said] "The only thing that you can do for me is to keep my kids safe."[Pat]

Other children were raised in an extended family situation, and their mothers' drug use was irrelevant to this arrangement.

IV. POLICE SURVEILLANCE

Due to their visibility as illicit drug users, many of the women were in contact with the police, either on the street, during drug arrests or in their homes. The criminalization of drugs and the resulting illegal market have created a situation in Canada of increasing criminalization of individuals. Illicit drug use is considered a "victimless" crime, and it is difficult for law enforcers to know who is actually using, buying and selling drugs. Most illicit drug users do not complain to the police, nor are they easily identifiable by other people in the general population. Accordingly, the police have developed many proactive and controversial procedures to obtain narcotic arrests and
Informants, disguised police officers and undercover agents have been frequently employed since the criminalization of narcotics. Stoddart (1982) explores the lifestyle of undercover agents, noting their disregard of the law and their abuse of the people they are interacting with. The police routinely trick and force people into selling drugs in order to arrest them. Undercover agents break the law, use and sell narcotics, violate trust and encourage criminal activity in order to arrest illicit drug users. These practices are dangerous, in the sense that society sanctions police criminality in order to persecute illicit drug users (Alexander, 1990; Cohen, 1985; Solomon, 1988; Stoddart, 1982; Wisotsky, 1986).

All of the women interviewed spoke about their problematic relationships with the police, the law and society in general. For the majority of the women, their visibility as illicit drug users in Canada led to police persecution:

I remember years ago, in the early 70s, we used to call the streets the front lines because that is where the war was really taking place at that time. [Theresa]

It's not a war on drugs, it's a war on people. [Linda]

It really is a "you and them" situation when you are using. And they play that to the hilt, too. I think they are just as into this game of cops and robbers, sort of a glorified image of themselves, but really that's all self-created, there's no reason to have this cops and robbers attitude.
around drugs. I just can't see police, R.C.M.P., giving this position up, because how could they justify their existence for all those years? And where else could they get to play that game, with narcs, and undercover agents, and wire tapping?[Hope]

Alexander (1990) states that the war on drugs in Canada fits the "pattern of a war of persecution" typified by the way in which heretics were historically treated (p. 50). The warlike activities associated with the criminalization of drugs in Canada has subjected an increasingly large segment of the population to government-sponsored surveillance and violence. In addition, women who do not fit the familial model of good wife and mother are less protected by police (Edwards, 1987; Radford, 1987). The women interviewed described how the police were conditioned to respond to them cruelly, as if they were not human and had no human rights.

Well, they have to be trained, you know....we've all met police who're civil, who can talk to you. But on the other hand,...I don't know how many years ago...we got a guard dog and it was trained. The dog was a year old. Gentle. This dog was as gentle...on command she was grabbing hold of here. And that's what the drug squad used to remind me of. I thought, how can they be walking along...a dog...how can they, on command...they become like...the dog would run and grab you...I don't know whether it's vicious. Now here you have...here's a man sitting in a park, gets out of a car, and within seconds...I couldn't do that. I couldn't get that hate, that anger, within...you know, if somebody came up and attacked my family I could, I know I could, I could kill somebody if somebody attacked my family. But to sit in the car, or just wherever and then within seconds....how do you get worked up to that, where you can kick a door down and choke someone?[Linda]
And for cops, they can be real problems. I mean they can want anything, money or sex. For just pure harassment of you. [Theresa]

They were also very cruel, treated you very badly the police. And really condescending. You know? They couldn't find any visible marks of using, so they would say crude remarks. "So where do you fix? In your snatch?" [Sarah]

When I was still hooking...and was using drugs or selling drugs of course the cops were always, always a concern to you. Uhm...but it wasn't because of anyone finding out any more. It was just because of the mess they were gonna make of the place and who was going to have to get kick[ed] around and, you know, shit like that. So, I don't think that anybody scared me after a while. [Theresa]

The "threat" of illicit drugs is perceived to be so great that government and police intervention is viewed as "noble" rather than suspect (Hadaway et al., 1991). Consequently, much of Canadian society believes it must be protected from illicit drug users. One middle-class woman discussed how the police treated her depending on the type of drug involved:

So, heroin addicts, you bust them and you treat them a certain way. And if somebody is getting busted for marijuana, you treat them like it is not a big deal....But you get treated differently depending on the drug. I don't know if that is necessary. [Sarah]

Although heroin, marijuana and cocaine are subject to the same penalties under the Narcotic Control Act, police may demonstrate discretion when choosing whom to arrest on drug charges. And Canadian judges have demonstrated discretion through sentencing. Heroin offences receive the harshest penalties. Marijuana offences receive the most lenient penalties (Health and Welfare Canada, 1991).
Even after some of the women had ceased using illicit drugs and engaging in other criminal activity, the police continued to contact them. Once they had been identified as illicit drug users, the women found it difficult to achieve another status in the eyes of law enforcers, regardless of their cessation of illicit drugs. Some of the women noted that when the police were actively pursuing their male partners, they were harassed and often set up:

When I was with T’s dad and we would get busted, they would...those laws affected me in that they used me to get him....Well, they just busted me and all of my family, to wheel and deal. So that they could get what they wanted.[Sarah]

I had cops fuck with me so bad. You know, especially if you are in a drug-dealing relationship with a man. They always fuck with the woman on little itty bitty shit though. For they’ll keep harassing her on...I mean I have had tickets for crossing on the wrong side of the crosswalk, for spitting, for dropping a cigarette butt, for a napkin flying out of a bag, any reason to give a ticket or harass you or get [you] into the paddy wagon...I mean, you know. Thirty days time for a joint. Fcr...having your name on the lease. I am charging you with all of the stolen property. Even if they know it is not yours. Anything....you know a lot of that is because usually the guy in the relationship is the one buying some drugs on a larger scale and so...they think the woman is the security in the relationship. So they always try to yank her out first. Not to do her any good though. Just as a jolt.[Pat]

we were constantly hassled in this small town....They never found anything because he really did stop dealing when we moved in together, but the cops just wouldn’t let him be. Actually, it was the R.C.M.P.[Hope]

Their visibility as illicit drug users led to harassment even when the woman had no criminal record and had ceased
using illicit drugs. One woman who has been on methadone maintenance for many years described how the police continued to harass her due to their suspicions about past drug dealing:

I have no criminal record....They don’t come to the door any more but we are still harassed. Always, always, always.[Marg]

Some women were able to avoid police harassment when they were able to maintain a conventional lifestyle, did not live in poverty and had not acquired a criminal record. Two women noted how differently they perceived the police now that they lived a more conventional lifestyle and had ceased illicit drug use:

Like, I used to hate the police, used to hate them. Now, it is, like, I don’t know, it has changed. I don’t know how and when and all, but I just changed.[Cindy]

I’m so straight now. And you see, my charges were dropped. So I don’t have that...I don’t even have a dislike of the law now. Now I actually look at them...myself, from where I’m sitting, I look at them with pleasant eyes, that they’re here to protect me again. I mean, I’ve done a hundred-and-eighty-degree shift. Or three hundred and sixty-degree shift because I’m not illegal at all. So I like them protecting us. But it’s a whole new way of looking at it. I don’t think of them as pigs any more. ’Cause I’m not on the other side. I don’t do anything illegal.[Janet]

For some women whc did not bear the stigma of a criminal record, and who were able to re-enter conventional society, the police no longer were perceived as the enemy.

However, as one young woman stated:

Like, I’m glad the police...if there was no cops I wouldn’t want to be around. But they definitely need to, educate a little more, especially with the police working downtown. They need to educate
them...from a different point of view, from a
different...Not from a legal, necessarily a legal
standpoint, because it's the way that they act. If
they start off and they come on strong and get in
your face...everyone downtown reacts. Anybody down
there will react. And if you act a little different
and try to show them respect, it doesn't mean
you're kissing their ass. Then they'll react with a
little more respect back to you, whether you're a
cop or not. If you deal with them as a human, not
as a "drunken fucking Indian" or "spic" or "god
damm junkie." [Karen]

Another woman in her late forties described her sense of
security now that she no longer participated in illegal
activity; however, this sense was partially derived from no
longer being witness and victim to the power that the police
wield when persecuting illicit drug users:

Yes. It feels really, really good now. Like, I
guess it is just the power that the police and the
system have. [Sarah]

The Narcotics Control Act gives licence to police
practices that most Canadians would find horrifying in another
context. Most women do not choose to live outside the law;
rather, many women have limited choices and act within the
confines of economic, social and political constraints.

Drug Dealing

The artificially high prices of illicit drugs make it
difficult for many women to finance their illicit drug use
through legitimate means, especially if they are poor.
However, as Waldorf, Reinarman, and Murphy (1991) highlight in
their study of cocaine users, the image presented by the media
of the ruthless drug dealer is faulty. In fact, most drug
dealers "drift" into dealing. To build on David Matza's
sociological premise, drug dealers are neither "compelled nor
committed":

Users often sell to defray the costs of their own
supplies, to get better quality drugs, or to assist
friends and associates in buying higher quality
drugs at quantity prices (Waldorf et al., 1991, p.
76).

Many women participate in drug dealing to finance their
illicit drug use (Rosenbaum, 1981; Taylor, 1993). Rarely do
women set out to "deal drugs." Rather, the combination of
their economic situation and illicit drug use facilitate a
"drifting into dealing." This drift may only entail pooling
money with other friends to obtain a better deal, or selling
small quantities to support their own drug habits. A small
minority of users sell larger quantities and transport drugs.
Traditionally, women have not been integrated into the larger
"cartel" type of drug dealing that is so popularized by the
media. Women are sometimes offered the role of the "mule"-
smuggling and transporting illicit drugs but this his type of
activity is less lucrative. Nevertheless it carries severe
legal penalties, including life imprisonment.

<table>
<thead>
<tr>
<th>Table 10-3</th>
<th>Participation in illegal activities</th>
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<tr>
<td>Total women: 28</td>
<td>n</td>
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<tr>
<td>Selling drugs and transporting drugs</td>
<td>14</td>
</tr>
<tr>
<td>Prostitution</td>
<td>11</td>
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<tr>
<td>Other</td>
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Eighty-nine percent of the women interviewed partially or totally financed their drug use through illegitimate means at different times. Similar to Fields and Walters' (1985) findings related to legal activities and illicit drug use, over a third of the women partially financed their illicit drug use by legitimate means through full- or part-time work. Outside of legitimate means, drug dealing was the most prevalent financial choice for the women interviewed (see Table 10-3), followed by forgery, prostitution, shoplifting, transporting of drugs and B & Es (break-and-enter). Selling the drugs appeared to offer a means to finance one's drug use as well as to obtain economic security, even though this was rarely realized. Seventy-one percent of the women interviewed were on welfare assistance at the time of the interview. Drug dealing offered a means to supplement an income that was insufficient. Like cocaine users and sellers in Waldorf et al. (1991) study, and the male drug dealers studied by Hagedorn (1994), the women interviewed maintained ties with conventional society and perceived their drug dealing as a means to supplement their income.

Over half of the women (54 percent) had participated in dealing and transporting drugs. Many had only participated in dealing small amounts in order to finance their own drug use. Many supplemented their drug habits by visiting doctors in order to get legal prescriptions. Double-doctoring was common, especially prior to the practice of using triple prescriptions.
which closely monitors the prescribing of specific legal narcotics by doctors and pharmacists. Eleven percent of the women obtained their drugs through legitimate means, and other activities. Thirty-nine percent of the women had worked as prostitutes, although 14 percent of these had also dealt drugs. Participation in criminal activity fluctuated according to need and availability. Many of the women (36 percent) participated in methadone programs either for short periods (up to three months) or for longer periods (up to 20 years). During that time, they stated that they ceased or limited their illegal activities. In addition, having a partner sentenced to prison might mean that the woman had to find other means to support her habit. Alternatively, price increases on the illegal market might necessitate visiting doctors for prescription drugs.

In short, one’s social and economic situation most often predicted what type of activity one might engage in to finance illicit drug use, as well as one’s own beliefs about certain activities. For example, two of the women stated that they were not able to participate in prostitution when they were poor, not because they thought it was morally wrong, but for other reasons:

Well, I just felt so corny, actually. I couldn’t...I didn’t think, yes, I don’t think that I felt sexy enough to stomp around like that. [Mary]

I remember being so broke, and really wanting to work the street. But you know what stopped me? Not my concern about whether it was right or wrong. No, I couldn’t get myself to try because I was afraid
that no john would actually want to pay money to be with me. What a fool I was. My self-esteem was so low, I couldn’t imagine it. Little did I know it has nothing to do with being attractive anyway. But looking back, I guess it’s o.k. it worked out that way, because I didn’t need more things in my background to be stigmatized about. I have enough without prostitution too. [Hope]

The majority of the women interviewed had few choices in relation to financing their illicit drug use. For the poor women interviewed who were dependent or addicted to illicit drugs, artificially inflated black market prices generally ensured that a conventional lifestyle would be impossible to obtain, let alone maintain. Some women supplemented their incomes through prostitution, although this choice often led to increased visibility as illicit drug users, and to lengthy criminal records.

V. PROSTITUTION

Some women who use illicit drugs engage in prostitution to finance their income. Similar to the low rate of prostitution in Taylor’s (1993) study of female drug users, less than half (39 percent) of the women interviewed had worked as prostitutes. Moreover, drug use did not always precede prostitution. Rather, poverty initiated an interest in prostitution (Rosenbaum, 1981). All of the women had worked as street prostitutes, though statistically street prostitutes represent "a small portion of the market." Street prostitution exposes women to more danger than does working in more protected environments, such as massage parlours or escort services (Shaver, 1993, p. 157). Researchers note that many
street prostitutes survived physical and sexual abuse in their youth. The street offered only an illusion of refuge, for women were subject to further violence and police harassment there (Johnson & Rodgers, 1993; Lowman, 1991). Many women enter street prostitution as juveniles (Lowman, 1991). However, the majority of street prostitutes in Vancouver work independently of pimps (Shaver, 1993). Some of the low-income women described their first experiences working as juvenile prostitutes:

And then the first time I had to go out, I had to work the street, you know. When someone picked me up I just cried. I cried to this guy, you know. He stunk, and he was disgusting. He was fat and ugly, and, you know, and I looked very, very young when I was that age and...I cried, you know. I didn't do anything with the guy, but I cried to him. You know, I said "Listen, my boyfriend is going to beat me up and...get really mad at me if I don't bring in any money." And than he got mad at me too. And he goes, "Well [why] do you think I should give you the money...You didn't do anything." And than finally I was crying so hard and everything he just gave me 20 bucks and said, "Here. Get out of the car right here"....My boyfriend at the time, he was watching, you know. Well, he was...off in the bushes to make sure nothing happened to me. So I got out of the car and he saw everything happen and he said, "Well that's the way to do it."[Sue]

Street prostitutes are often the victims of violence. One young woman describes being attacked by a john:

One problem with the industrial areas is if they start to attack you there's no house to run to. But I found once, when I was being attacked and I ran around, and I knocked, they wouldn't let me in. It was just like in the movies...they wouldn't answer the door....He drove me all the way...I think it was North Van. North Van. And he wouldn't let me out of the car. I was trying to hit telephone poles, cops didn't stop...people didn't stop...I'm yelling and screaming. I finally get out of the
car, he’s chasing me with the car as I’m running and people would not answer their doors. I said, "Can you just call the cops, you don’t have to let me in...call the cops. I’m not gonna"...but I can see their point, too. You know, you see some...you know, I can see their point of view, too. But....to think that what if I was just jogging, because I didn’t look like a hooker then. I could have just been anybody. [Karen]

Prostitutes are much less able to exercise their rights than other women and are subject to considerably more violence (Edwards, 1987; Radford, 1987).

The women also spoke about their interaction with undercover police, for the use of surveillance and undercover police activity is common practice in regulating prostitution as well as narcotic offences. One young African American woman noted:

No, I didn’t get caught for drugs. I ended up getting caught for prostitution...Which was really sad because I never actually ever slept with anybody for money. I tried to do it twice and both times...the first two people that I talked to were cops....It took five years for me to try again after the first time. Then I tried again and it happened exactly the same way....I just say, well, obviously, I was not meant to be a hooker right? I fought for one [charge], actually. It was entrapment, the guy asked me like six times and I said no, no, no, no, no. Yeah, then he told me that I could have one hundred bucks. So I said ok, well...I told him to go away....He said, "God, no one has ever said no to me before." He was getting all sort of offended, even. You know, it was like, well, God....I said, "No, like, look." But finally when he told me how much money he had. "Well, how far did you say that you had to go?" And....I don’t know, we walked down there and, well, you are under arrest. Oh, no, I had a feeling all of a sudden. It was strange, though. You know, how you get that feeling just before, that they know everything. It is always too late....I knew...all of a sudden, I knew he was going to pull out a badge instead of a key. And I sort of waited to see, like I could have
just said, "Oh, on second thought, no, I'm lying" and left. But, no, I just had to wait and see if it was true...But what pissed me off was how many times he asked me...When I was getting fingerprinted, because I didn't show up at court. I had missed court and he put me up for failing to appear and his partner was the one that fingerprinted me. And I was describing the way that I got caught. He said, "I remember you." That sounds like something my partner would do, he said. I was, like oh God! [Mary]

Police subject women working as prostitutes to an array of underhand practices in order to lay charges, just as undercover police entrap illicit drug users. Upon arrest the stigma attached to prostitution greatly affects women. Sometimes they even plead guilty to charges that might have been dropped:

Yes, I just went and pled guilty, because I didn't want them talking about it, because I know too many people in those court rooms. Oh, God. I knew, like, I could go through the whole trial thing and probably win, but I just couldn't be bothered. I didn't want to be spending time in court. I just didn't want it spread around. Like, the more it is time to go to court, The more times I am bound to see people that I know in there. [Mary]

I guess when I first started hooking out of poverty and I had the kids with me. I hadn't really got into any...any drug abuse....I started the prostituting first. It was a way to get out of my finance problems which were killing us. And...I was so afraid of the cops. I was so afraid of being busted. I was...I was afraid of anyone finding out what I was doing. It was like...and I had no idea what the consequences were of what I was doing, but, mostly...was I didn't want anybody to know. And having run ins with the law, meant people finding out. [Pat]

Poverty, not drugs, is often the impetus to engage in prostitution, although illicit drug use is often an associated factor (Erickson & Watson, 1990; Johnson & Rodgers 1993;
For many women, especially for street prostitutes whose working conditions consist of long hours and dangerous streets, prostitution is not very lucrative. Working the streets once children are born often changes a woman’s lifestyle as well. The responsibility of maintaining a family and a drug habit and working the street was common to 34 percent of the women interviewed. All the women interviewed were low-income when they engaged in prostitution:

The second time A. was about two or three...Two, two and a half. And again...the dope was really bad on the streets and because my husband wasn’t working and all this. I was screwed. You know, I hadn’t worked for years. I am not exactly frightened...you know, to keep up the family money going. You know, in that manner. So, I went back to work. And...I guess having a child sort of changed this situation, that...you know, there was a little more guilt, because again, I mean, you are working long hours out there to make money. That was a time that was in the early 80's, in the depression as well. I mean, I knew girls that stood out there for ten hours some nights and made no money. You know, you would see them there at 8 o’clock the next morning, you know. You just want to cry for them. [Theresa]

It is probably important to know that I have been hooking for a while. That is how I got to doing cocaine and things. You can’t really look after kids all day and hook all night and back again. It got me out of my poverty problem, which was cool for a while, but keeping up the lie with everybody about what I was doing with my life. Everyone was pretty content to go...well, at least she has some money now, you know, and the kids have bikes and clothes and this and that. [Pat]

As long as their prostitution was hidden, the mothers were perceived as taking care of their primary responsibilities. However, once their prostitution became public through arrest, the law did not protect them; the women
became aware of the danger both johns and police presented to them, and often they became hardened to the subsequent police harassment they would experience:

Over the years...when I was still hooking and...and was using drugs or selling drugs of course the cops were always, always a concern to you. [Pat]

For a woman who lacked other marketable skills, if her drug habit increased or if drug dealing became less feasible, prostitution often became a solution to financial difficulties. In short, poverty led the women in this study to work as prostitutes. One woman lived with a drug dealer and when their relationship ended she began to engage in prostitution:

At first I just lived with a dealer, and whatever, and when the last one went to jail I was up so high, the amount was so high everyday, it wasn’t possible to do it that way. There wasn’t enough money for everyday things. [Greta]

The difficult life of the street prostitute who is participating in heavy illicit drug use is captured in one woman’s assessment of her life when she was poor and addicted to cocaine:

Women on the street are battered about between men and the law, back and forth, back and forth. Prostitutes’ life is between a fuck and a fix. A fuck and a fix. [Pat]

For some woman, prostitution and illicit drug use often went hand in hand. The double stigma of illicit drug use and prostitution was evident as the woman’s criminal record expanded. One native woman described her early criminal record:
Prostitution. Prostitution, failure to appear, breach.[Sue]

Unlike her male counterpart, the female drug user is often more visible to police scrutiny when she engages in prostitution (Lowman, 1991). Within a short period of time she can acquire a lengthy criminal record that often has far-reaching effects in terms of sentencing and of her ability to keep her family intact. As previously mentioned, women who engage in prostitution are more likely than their male customers to receive criminal records and punitive sentencing (Shaver, 1993).

VI. RACE, CLASS AND GENDER

The race, class and gender issues underlying drug legislation and enforcement have been explored by critical researchers (Alexander 1990; Blackwell, 1983; Boyd, 1983, 1984, 1990; Brecher et al., 1972; Faith, 1993; Gómez, 1994; Humphries et al., 1992; Maher, 1992; Preble & Casey, 1969; Reinaman, 1979; Rosenbaum et al., 1990; Szasz, 1974). Poor women and women of colour are most vulnerable to police harassment and arrest (Adelberg & Currie, 1993; Chunn & Gavigan, 1991; Bloom et al., 1994; Faith, 1993; Johnson & Rodgers, 1993). The unequal treatment in police discretion and later in sentencing was evident to the women interviewed.

Native women who were interviewed acknowledged the existence of institutionalized racism within the judicial system. Some believed that they could respond to it proactively:
If you stand up for yourself and you don't cower in a corner like you see some people do. If you stand up for yourself, then they know that you are not a weak person...so just because I am native, that is not going to stop me from saying what I want to say. [Cindy]

Standing up for themselves empowers women by giving them a sense of agency. Unfortunately, current drug legislation and race and class bias undermine personal attempts to maintain agency. Research that demonstrates that criminalized women, and women who use illicit drugs, suffer from poor self-esteem is simplistic. As Gavigan (1993) notes, poor self-esteem may be a result of "being labelled and incarcerated" (p. 228). Racism is also problematic; Monture describes how racism is a type of violence that can’t be touched or seen, which renders it invisible (Monture et al., 1993).

For women who are arrested, the racial and class composition of prison is a lesson in Canadian judicial inequality. One woman of European heritage described her time in prison:

And the loss, like, it just floors me, like the whole thing about the native population...It was, like, 87 percent native women. In for stupid little things, like...I mean the average stay was a month. I mean where were their children? Their children were either taken away or in bad situations. [Carol]

And a native woman noted:

I never felt like I belonged, being called a dirty Indian, or this or that. [Cathy]

One young woman of European heritage spoke about her perception of racism and police activity in downtown Vancouver:
They...how to explain it...it's not so much that they don't hassle white people, but natives and Spanish, they definitely hassle more. They definitely, because it's the stereotype. With Spanish, they're all drug dealers...but that's downtown. Right, some of them aren't and it's not fair to the ones that aren't. But they do get hassled more. Natives get hassled more....But it's almost like they're prejudiced not because they're personally prejudiced but because the policy...it's just because of patterns that happen downtown. That they're just going with the patterns and it's not really that they're personally prejudiced. Some of them are. But, yeah, I definitely got hassled less but that's also because of the way I appeared, too. I mean, there's a lot of white girls that dressed like tramps that got hassled, too. I just tried to keep as low-key and kind of plain and not draw attention to myself and keep quiet and low-profile.[Karen]

Another woman of European heritage described her interaction with the police from the vantage point of class and her status as a single mother while living in a housing project:

Well...they are all negative. I mean you always...you are given a negative reaction right away from everybody. I mean you have...the police come for an unrelated incident....they are coming in to a housing project, I am on welfare. I am a single mother with a teenage daughter. Even without the knowledge of anything else. It is like, "XXX", right away.[Evelyn]

In addition, the women spoke about their difficulty in protecting themselves when charged with a criminal offence due to their low economic status:

My family was working class, poor, but then I was on welfare too and a single parent. Life is so different now that I have moved from that class. I am treated so differently. I'm glad that I had a chance to see how white, middle-class people are treated, because that is a new experience to me. Being raised working class and then on welfare, no education, no access to money is very different.
The police treated me and my family very different. The interference in your life is different. When I was young I went through juvenile court and it was so obvious that we were seen as scum, my parents, too. It was a kangaroo court. Later cops who busted my house, I was a piece of shit in their eyes. I mean really, who could I complain to if they treated me badly? I think they know this, too. Now it’s different, but I never feel too safe. [Hope]

So right from the beginning...I was found guilty of possession for the purpose [laughs] and so right from the beginning, the laws, I felt, were against me as a woman and as a poor woman and they were pro this guy who had the good lawyer and whose father had money. [Carol]

And I have grade school education. So, uhm...I think that a lot of times, that people talk to me like I’m illiterate or something. Or couldn’t make a conscious choice about anything, because I don’t understand the issues involved. But I do understand my own life and my own needs very well. [Pat]

In contrast to women who are more visible and less protected in society women who came from white, middle- and upper-class families were buffeted from many of the negative consequences of the law:

So, we got arrested together and because I come from a family where they’re white and I would say, middle class, with educational prestige, because it wasn’t that we had money but that there was the prestige of having a father who was involved with the law and things like that...that it was the first time I was aware of the double standard, because the person I was with got sent to juvenile detention and she wasn’t even responsible. I mean, she wasn’t even...it was me that was doing the whole trip. ...So I was absolute, I was angry, I was dumbfounded. I mean, certainly, part of me was relieved, ‘cause I didn’t have to go spend the night in juvenile detention. But another part of me was just amazed, ‘cause I had never seen that distinction before. And to see how blatant it was, how incredibly blatant the whole thing was. [Debbie]
Yeah, I was afraid I was going to go to jail with two little kids sitting outside, and if my mother hadn't helped me with the money I would have gone to jail... so I mean, you're talking about women with money and women without money. [Janet]

Out of maybe 15 charges I spent three weeks in jail. I was lucky with my lawyers, because my family, when I was young, there was a lot of deaths in my family with caretakers and stuff, because of that and because, I think partly because I went to university. And I, it almost seemed like the lawyers would play, well the last five or six years I had the same lawyer, sort of played with the mighty fallen kind of thing. I got off easier, like I had struggled so hard and then fallen. When actually, I don't know if I did struggle much. [Donna]

Because my husband kept me away from a lot of it. I would have either got into a lot more trouble or I would have quit using if I hadn't been with him. But, I was arrested for heroin, morphine a few times, and I didn't go to jail. I think that I didn't go to jail because...well, I was working and I was able to get recommendations and support. And because I knew how to present myself. So, I think absolutely that... [class] makes a difference. [Diane]

Presenting oneself as a member of conventional society is paramount when interacting with the criminal justice system. If the women could portray themselves as middle-class, or upper-class, with social and financial support, they discovered that the police used discretion, and the judges were often sympathetic. Furthermore, past loss of child custody, single parent status, welfare recipient status, and lengthy criminal records often were perceived by the criminal justice system as signs of deviance. The women, and especially women of colour, were punished. Poor women of European heritage were punished as well, and some of these women spoke
about their belief that their sentencing was harsh because the judge wanted to make an example of them for transgressing into criminal behaviour. This was evident upon sentencing and parole hearings:

The parole board itself decided not to let me go, and they said the reason was my age, because I was 32 when it happened....because...I was white and I had more opportunities because I came from C. 'Cause I had every opportunity not to do it. And on the map C. is a rich area. It's a ridiculous system. It's very corrupt. And these few people look at your files and say who goes and who stays....But they just said, "We're giving you an eleven month hit." [Morgan]

White women do suffer persecution as illicit drug users, and it is safe to say that all criminalized women receive harsh treatment within the criminal justice system, especially women who are perceived as "undeserving" (Edwards, 1987; Radford, 1987) But the institutionalization of racism has far reaching effects for women of colour, and all of the other women interviewed claimed that women of colour had a more difficult time than they did in relation to police harassment, arrest and sentencing.

VII. REENTRY

The parole board plays a significant role in the release of women who are incarcerated. It is well documented that the National Parole Board has not been consistent in "establishing clear and consistent criteria for release decisions" (Griffiths & Verdun-Jones, 1989, p. 452). The discretionary power of the National Parole Board has been problematic for many women hoping for release, including some of those
interviewed for this study. One professional woman from working-class background noted:

I had no trouble with the law at all until...ten years later, when I was a very casual user of hard drugs. I would say if I used once a month I would be...I would worry that was too much [at the time of her arrest]. And...so I just assumed I was going to get my parole and they turned me down. That was devastating to me. And I thought...as a mother....It had absolutely no meaning that I was a mother who had a relationship with this child and who...had a really good plan on release. I think one of the reasons I never got it is that C. and I were still together. And because he was an addict, they looked at him and what he was doing, instead of looking at me and what I was doing.[Carol]

Another woman from a working-class background stated:

Oh, yeah, the other thing about the parole board, is when you go up before them...they decide right then and there...sometimes they decide before. But...I heard this from the other inmates there,...I don't know if this is true, if they think you are probably not going to commit another crime, if it’s mostly then a one [time] thing, then they might keep you longer. Because I knew so many people who were in, you know, the revolving door, or recidivism. Where they are in and out, and in and out. In some instances they let them go because they know they are coming back. So they don’t worry so much about it. Like, that’s from an inmate point of view. And that’s what they told. But I listened to the inmates because they know a lot, they really know about the system really well, plus it’s the inmate point of view.

And so I thought about that and I thought that might be true because I knew, I knew I wasn’t going to risk, I felt what happened to me....You know, I didn’t have a record, for one thing. I didn’t have any record for ten years. Like I did stuff when I was younger and then I went through a long period of time when I didn’t get in trouble...and then they brought it up in court, the stuff that happened when I was a kid....But they just said, We are giving you an eleven month hit," which meant I was doing eleven more months conditional time. Which was a big disappointment to me, and considering I had a child, and I tried to tell
them, you know I had a child, a little four-year-old son.

...it's almost like you go into a dream because you know you have a chance to get out and you've done the best you can while you're in there, there's nothing more you can do...what I did was a series of banks so they looked at every individual bank as a separate crime. So they said because there were so many...[Morgan]

The women had hoped that their good behaviour and their status as mothers would be acknowledged by the parole board. But in fact their status as mothers, rather than compelling leniency, appeared to compel punitive decisions from the parole board. Similar to other research (see Carlen, 1983; Daly, 1989; Eaton, 1986; Masson, 1992), the women in this study believed they received more severe sentencing for failing to assume the proper gender role of the "good mother". The master status of "criminal" overrides their status as "mother" as women enter the criminal justice system (Faith, 1993).

For women whose partners were incarcerated, parole board decisions were also significant. One woman discussed her husband's difficulty in receiving parole:

But he's really quiet...so...one time he didn't get a parole....And I see people out there also who, some of them...they can't write....and it's really hard. It's hard enough in society in general. Then you get a person who's coming up against the system, and it's really hard, you know.[Linda]

The parole board and the criminal justice system as a whole can be problematic for individuals who are not verbally articulate or who cannot write well. This often has little to do with a lack of understanding on the part of the criminalized women; rather, the professionals they encounter
treat them as inferior and incapable of making decisions pertaining to their sentencing and release. One woman on social assistance noted:

all through arrest, or court, or social workers... All that stuff, they all go ahead and make all kinds of decisions without even consulting you or even letting you know that anything is in the process of being done. It just makes you feel like a rag doll....It is so combative every time you try to open your mouth that after a while, you just say, "Fuck, what is the point? Let these people do what they are going to do and I will just go on about my business and hope that they don’t fuck with me too much."[Pat]

Although drug treatment was not available to the women interviewed during their time in prison, some of them noted that it was difficult for drug users to be honest with prison staff about their drug use, especially since this may affect their parole:

Say for instance in prison, where people will go in and the ones that can express themselves will go up to counsellors, tell the counsellors just what they want to hear....so they’re afraid to be truly...honest...being in jail and you’re a drug addict, well, "When you get out are you going to use drugs?" Well...in fact Brannon Lake had a questionnaire like that. What were your feelings. And if you say yes, they’re going to know...or you’re going to say, "No, I’m never gonna use"...Well, you can’t, because if you say no, you’re never going to use drugs, they know you’re lying. If you say yes, you’re not going to get a parole.[Linda]

Women who use illicit drugs are often in a double bind when answering questions related to their drug use. Although many of the women knew they would return to either legal drug use, such as a methadone maintenance program, prescription drug use or illicit drug use, abstinence was the required behaviour for
release. Furthermore, illicit drugs are available in prison (Barry, 1992). One woman of European heritage noted that while she was in jail she was committed to abstinence due to the penalties for being 'aught:

I was institutionalized for so long, and I was basically away from drugs, although there was drugs in jail too. [Morgan]

Briton's (1995) study within the U.K demonstrated that offenders are unwilling to share tales of drug misuse with probation officers due to their fear that they will lose more than they gain. "At risk is their liberty, their sources of drugs, their relationships with parents and school, their children, their partners, and their jobs or welfare benefits" (Briton, 1995, p. 16). Canadian women are also reluctant to discuss their illicit drug use with criminal justice officials. One professional woman described her attempts to conceal her lifestyle from criminal justice officials when she was poor and on probation:

When I was on probation I never responded to any of the personal questions asked by the probation officer. I knew my private life would be seen as further evidence of my incorrigibility. And I was having a hell of a time just maintaining an acceptable social front at that time. [Hope]

The transition out of prison could be fraught with problems. Reunions with partners and children were sometimes happy moments. However, the long separation often traumatizes children, and mothers have to work on both their children's problems and their own upon release. Most of the women had not been offered counselling or drug treatment during their
incarceration. Upon release they found many issues pertaining to their drug use and their status as criminalized women unresolved:

The jail wasn’t set up at all to accommodate anybody that was doing any kind of long term, and there was no rehabilitation of any kind. They didn’t have any counsellors that knew how to do any kind of therapy, that were, where I could gain any insight about myself. It was all just work on yourself. You know that isn’t always successful. [Carol]

I spent time in jail for drug-related crimes....A lot of problems just being in jail and then having to come back out. And that’s going to be a life-long thing for me because I still have a record. [Morgan]

Many of the women had taken initial steps to receive a pardon if they had only one or two criminal offences related to illicit drugs. One middle-class woman who had been convicted of a narcotic offence described the difficulty of obtaining a pardon:

No, I sent away for all the stuff for a pardon. I got the stuff back and...I never took it past that point. I haven’t got the pardon yet. You have to put down the names of two or three people that they can interview about you. Who can I ask? You would also have to know someone that you didn’t mind knowing about your charges. Mind you, it was just marijuana, but even so. But that doesn’t matter, it was a tiny little bit, it shows up as possession of narcotics. I could have just had a ton of cocaine or something like that. And now, I should really get that pardon, honestly. I started about two years ago and there my finger-prints sit...So now I have to go through the whole ordeal again. And what...was really frustrating was when I got my record back it showed that I had got a conditional discharge with probation, because it was a gram and a half of marijuana. But it didn’t say that. It just said possession of narcotics. And when you get 18 months suspended, I mean probation, you might think, God, this was really bad. But it wasn’t, it
was marijuana. On top of that...when I got busted for shoplifting one time and I beat it. That was also down there.[Gloria]

The stigma attached to illicit drug use hinders women trying to re-enter conventional society. Many of the women interviewed had few friends or family members who would be eligible to be interviewed for the pardon. Often the people available had criminal records themselves, or lacked professional status. Looking outside their own circle of friends and family meant having to reveal their past, something that many of them were reluctant to do.

For women re-entering conventional society after release from prison, race and class were of primary importance. Poor women had little economic support. Women of colour had to face the same institutional and personal racism that accompanied them to prison. Having a criminal record made re-entry more difficult. One low-income woman spoke about the difficulty she had in finding employment. She noted that her visible prison tattoos on her hands, and her visibility as a women of native Indian heritage contributed to this difficulty:

I wanted to work with children.... So I went out....I was so stupid, I went out to West Vancouver and I was going out to these rich people’s places. Going for interviews. I sounded really nice on the phone and everything, but when I went there, you know, people saw that I was native and got turned off.[Sue]

Women who were able to maintain a semblance of middle class status were often able to hide their identity as criminalized women and drug users. Participation in a
methadone program enabled one middle-class woman of European heritage to enrol in a graduate program and to re-enter society more easily than other women who had no access to education and social and economic supports:

I am sure that after university or anywhere I go, I am sure that nobody would be able to guess in a million years that I was on methadone. [Diane]

A successful re-entry into conventional society is obviously relevant to recidivism and stabilization. The availability of non-judgemental economic and social support is paramount.

The criminalization of specific drugs has made it difficult for women to re-enter mainstream society, for the social stigma continues long after one ceases illicit drug use and criminal activity. Criminal charges, social service intervention, child apprehensions by the Ministry of Social Services, medical records, school records and physical scars can all become evidence which permits discrimination.

Many of the women described their painful attempts to re-enter mainstream society:

Coming back into your life and trying to put it back in order. Within the system it is so difficult....maybe some other societies it wouldn’t be looked upon as so awful, people can bounce back. But in our society there’s no bouncing back, you are out. And if they don’t do it to you, you do it to yourself. This has been my worst problem....Where I have literally oppressed my own self. And I put myself down and said, "Oh, no I could never do that. No I couldn’t do that. Because I’m not, you know, because I’m so awful"....And I’m just starting to think I’m not awful, I’m not awful. You know, even if I said to myself I wouldn’t hurt anybody. It’s like...the system has made me afraid of myself. And distrustful of myself. But I see with my children how much I love
them, and how much my children love me, and my boyfriend and my family. And if my family loves me and my children love me I'm not so bad. I mean, who is the system talking to, who are they talking to, and where do they get their information from, and how do they impose their moral judgements upon others? [Morgan]

But, unfortunately, when you are trying to live within a system, and now...I have made a decision that I am going to be part of that system, as far on the edge as I am. I think that it is a healthy fear, to be afraid of those things. To say who I really am. It is an ongoing struggle for me, though, for sure. [Carol]

I kicked that habit and I went on to get straight and...and live normal or whatever that was. I got a job. I had my first kid, you know, a couple of years later....But I felt...it was really weird having to invent a past. I was pretty young still then in my 20s. And I had never been to high school. I had never been on a date. Had never done anything that most people that I was talking to were still talking about. And so I had to invent this past, which was really, really weird. [Pat]

For women who wish to be honest about their past and regain a sense of their own integrity, the stigma and legal sanctions surrounding illicit drug use make re-entry problematic. These women spoke about the oppression they experienced as women who have children:

As a matter of fact, even now I think that if I were a man, I would be a lot more comfortable to share my background and be accepted, but because I am a woman, I feel more pressure to hide that because it goes so against society's view of what a woman is supposed to do and who she is supposed to be in terms of nurturing and children and...being the one that always is...doing what she is supposed to do. I mean, I reject all of that. I think that it is a bunch of poop! But, unfortunately, when you are trying to live within a system...[Carol]

Well, being a woman in itself, there's a lot of oppression in that sphere. We may not all see it, we may not be all willing to admit it, but I felt
there's a lot of oppression in just being a woman. Especially being a woman with a low income. And then, you know, [oppression] by males, and if your self-esteem is low, the person you envision yourself with, once your self-esteem is at that low point, you don’t, you just don’t envision yourself with a college professor or a lawyer. You see yourself with, you know, someone who may be abusive to you and may be oppressive to you. So, it’s just layers of oppression and repression. It happens to us, other people expect us to be this, and we become this, and we expect a little bit from ourselves. [Morgan]

Many of the women noted that their options were limited as women and as mothers. Their past was reflected in their present and future, and options were limited in their private and public lives. In addition, many of the women carry physical scars related to their past drug use. Abscesses, needle marks, etc., are often difficult to hide:

This is a miss, on my arm, and on my hand the doctor had to cut that one, and this one is a miss too. This vein the centre vein, is all broken, there’s no main vein here at all, this one is too calloused. [Jill]

There are some things about people that, sometimes, I can pick out the ex-users. There are certain body scars that just don’t, will always...[Pat]

Straight women like men who live a little dangerously, who have a past. You know, a tattoo looks o.k. on a guy, or a wild past. But for women who are trying to find a straighter life, their past is not looked on the same way. If a women has lost her kids, that’s seen as horrible. If she has track marks, tattoos, this is not so attractive to straight people. [Morgan]

For women who have a past, especially a criminal past, body scars can signify criminal status (Faith, 1993) and complicate re-integration. Rosenbaum (1981) notes that women who have a history of illicit drug use are viewed as "damaged
goods" by society (p. 132). Social attitudes dictate that a certain degree of deviant behaviour is tolerable in men, but women are punished for past transgressions:

We really judge women who use way more critically. But especially mothers, she is despised because drug use means you are a bad mother. But my feelings for my kids is the same as it was when I used. It hasn’t changed. It angers me that women carry the brunt of these things. Men take such little responsibility for anything in our society. And raising kids on your own is difficult and the price of using drugs is so much higher for mothers.[Hope]

A woman’s illicit drug use, and especially that of mothers, is regarded differently from male illicit drug use. Return to society is often perceived as conditional. One mother of two children who is working towards her university degree stated:

I feel like I just have something inside of me, and I’ve been allowed to bounce back. I’ve been allowed to. I am fighting back, but I’ve also been allowed to do that. Because they could have put me in jail forever, or I could have been refused welfare, or might not have been able to get my grants for school.[Morgan]

For many women, their criminalized status continues to affect their lives even after they stabilize and discontinue illicit drug use.

VIII. CRIMINALIZATION AND DECRIMINALIZATION

The persecution of illicit drug users has been accompanied by stereotypical depictions of drug users by the media. Drug laws and the media’s depiction of the dangerousness of illicit drug use often shapes societies view of who illicit drug users are. Many of the women interviewed discussed the negative media attention illicit drug use is
given, as well as the glamorization of drug use. Another concern was the more aggressive war on drugs in the U.S., and how Canada may be affected by U.S. policy:

If the propaganda changed then people’s ideas would start changing. You know, if they start seeing the reality of what they are doing, the whole subculture they are making...this desperate subculture, it’s just craziness. [Janet]

There used to be more money spent on educating people with...you know, reefer kind of madness. Kind of misinformation, dis-information. [Diane]

These insane images the media and government has created of drug dealers is just like the images they create of enemies during wars. It’s pure propaganda. And look how the U.S. is combining those images with Norego, the drug dealer, the enemy, which gave the U.S. the impetus to invade Panama. It’s quite frightening. It is obvious that prohibition does not work. We saw that during alcohol prohibition, the laws created more harm, violence, black markets, and actually more consumption of alcohol. That is what is happening with drugs too. But we don’t want to face this. I don’t know if it is our close proximity to the states, but I wish we would develop something different. I mean, look at it there. But it’s terrible here too. [Hope]

Yeah, I do think they should legalize it. I really do. I mean, it’s not going away. They are talking about the army going down to Columbia. I mean, it is just stupid, you know, in the States, it really doesn’t make sense. It’s like an industry now, there’s this big industry that sucks off of drugs being criminalized. And the criminal element gains from it. And the police agents and the weapons manufacturers and all that, they benefit from it being illegal. But I mean. Keeping it illegal doesn’t really make much sense. [Gloria]

When I started using I think one of the reasons, and now it seems ridiculous when I look back...but I think I used because it was illegal...and I really believe that if they decriminalized it, it would deglamorize it. And I think...well, it’s just not glamorous, but the media tend, even the police are affected by it....I really believe if it had
been legal, for me...I wouldn't have. It was sort of like a no-no, the ultimate no-no. [Linda]

Other women spoke about the long-term effects of the criminalization of certain drugs, as well as their sense that they were not protected by the law in general. The drug laws affected both drug use and choice of drug, as well as lifestyle. Some of the women expressed a general weariness with the lifestyle:

I am just tired of the game, you know. I am tired of quitting, starting up again, getting really involved. This is a big circle. If they had left it legal, I probably to this day would be a chippy user. You know, semi-wired. But, I mean, probably life long. You know, but it probably would have been a fairly even use of drugs. Like, you know, somebody going out for a beer, and in the evening having a pipe of opium or whatever. I would have been happy as hell. Why people have to get involved and tell you this is wrong and my morals are all screwed up. Their morals are all fucking screwed up man. They just, they damned near destroyed this family twice. [Theresa]

But maybe if the taboos were not so restrictive and if the legal position was changed and things are loosened up a little bit. Maybe that wouldn't happen, maybe that wouldn't be the inevitability of it. Maybe a person could, you know, like maybe they actually could be, because, you know, I smoke pot in a perfectly acceptable way to me. I can not smoke pot for six months and it doesn't bother me at all. And then I'll have a couple of tokes and have a really good time. I love it and that's the end of it. But it doesn't. I don't care. Once in awhile I think, "Oh I'd like a toke," but it's more like "I'd like a jelly doughnut you know." I mean it's not a big deal. [Gloria]

But most of all it was the fear, the worry, that I could be busted. At certain times I didn't worry, like when I was a kid. But as I got older it did worry me and I didn't want to live with that constant fear or harassment. I didn't want to be treated so cruelly either, by cops. [Hope]
Yes. I mean, there the law and the system is screwed....Yeah, I mean everything is screwed. You know, the whole law sucks. I have no respect for the law. Why should I? Nothing has helped me in the past, you know.[Liz]

Other women discussed the health and moral issues surrounding which drugs are currently legal and illegal in Canada:

You know, what drugs are, these drugs are o.k. but those drugs aren’t o.k. And it’s a moral issue. And o.k., what if they made alcohol illegal like they did, would the price tend to go up? What if they make cigarettes 20 bucks a cigarette, which could happen.[Morgan]

I don’t think the law...you know, you can’t, you can’t legislate morality.[Linda]

I mean, it is out to lunch. I mean, this war on drugs...they are letting out child abusers so that they can make room for all these addicts. The costs, I mean, it is just wild. If there are aliens out there, they must just think...bizarre.[Diane]

Several of the women expressed their concern that the way professionals and society in general treated them influenced their options and responses. It is interesting to note that the majority of the women viewed their drug use as their own responsibility. Very few described their drug use in terms of the disease model. Drugs, both licit and illicit, could be used responsibly:

I’m not justified in doing that either [forgery], but the drugs didn’t make me do it. I actually did that. But I, I don’t, I just think I had a lot of anger. I had a lot of anger.[Morgan]

But, I mean...like alcohol....You have got to be responsible that you don’t drink and drive and you have got be responsible how you take your alcohol. I think that would be the same thing for any drug. I mean, anybody can do drugs, responsibly or
irresponsibly. Anybody can do it from a doctor today. You know, they can get their pills and their, you know, as prescribed or not.[Evelyn]

The majority of the women interviewed felt that drugs must be decriminalized in Canada:

I want all drugs legal. I am a total anti-prohibition....You know...laws against personal freedoms never worked. It is as simple as that.[Theresa]

I don’t think any person should be penalized for drug use itself. That is not a crime, nor is buying it or selling it. We need to decriminalize drugs, to offer more organic drugs, opium, liquid cocaine, try to move away from the more potent pharmaceuticals. Try to re-establish drugs back into our society the way they were before these laws. Just a fact of life.[Hope]

Well, I think...it should not be illegal. Addictions should not be illegal. It should not be illegal. I think it should be provided for us, whether we have to buy it through prescriptions or whatever. I think it should be decriminalized.[Diane]

I think the law is...I think they've got to get it decriminalized. They certainly have to decriminalize marijuana and hashish and they have to decriminalize narcotics...[Janet]

I think they have to legalize drugs....I mean, I just think it is the sensible thing to do.[Gloria]

Many of the women recognized the need for dialogue about decriminalization; however, they did not want to reveal their own drug use for fear of arrest, loss of employment and social alienation. One woman summed up a lot of the concerns surrounding illicit drug use-the stigmatization of use, the cost, the fear, and the need for open dialogue:

Because of the ways that the laws have gone, we see those people as bad....we tend to...like, as a society to blame them for the ills of society
instead of understanding that...if we considered decriminalizing everything, I mean...to me, we would be much further ahead. I mean the government is spending millions and billions of dollars in North America on fighting a war, quote, that they all know that they're losing....but, you see, it is not for even myself to speak out against...to speak out against making more laws and making them stricter. It is...you know, it is often hard to do that. I live in a really conservative province. And as a social worker, I want to be able to say those things, but I also worry that there will be ramifications if do. So, I am very hesitant and I really feel out...the group of people I am in, before I say what I really feel. But, I think that if everybody that felt, that was comfortable to start talking about it, that it might create a dialogue. I think that is what we need, Is to begin a dialogue. Because if people don't talk about it and talk about how they really feel, it will never change.[Carol]

IX. CONCLUSION

Women who use illicit drugs are stigmatized and criminalized. Women of colour, poor women and more visible users are the most vulnerable to arrest and police harassment. But few of the women interviewed, whether poor or middle-class, were able to escape acquiring a criminal record for drug and drug-related offences. With few economic options, women drift into drug dealing, prostitution and other nonviolent crimes to support their families and their illicit drug use. However, in contrast to media images of illicit drug users engaging in predatory illegal activity to support their drug use, the women interviewed also participated in legitimate part- and full-time employment and maintained ties to conventional society.
When women are released from prison, even if they have ceased their illicit drug use, re-entry into conventional society is often difficult. Stigma, criminal records and temporary and permanent loss of children have far-reaching effects in terms of employment, future relationships, continued police surveillance and harassment and subsequent problems associated with the loss of children. The women interviewed viewed mothering and family caretaking as their primary responsibilities, although their status as criminals overshadowed their status as mothers in the criminal justice system.

The criminalized status attached to women who use illicit drugs contributes to their lack of legitimacy and voice in Canadian society. The Narcotic Control Act legitimizes punitive government and police activity that erodes civil liberties, and women (and men) are persecuted. The contradictions inherent in the Narcotic Control Act are evident when the dangerousness of legal drugs such as alcohol and tobacco is examined. Tobacco and alcohol are our most dangerous drugs, but the Narcotic Control Act maintains a social fiction relating to the "dangerousness" of specific drugs. Although it is socially unacceptable for women to drink heavily and smoke tobacco during pregnancy in North America, the criminalization of women who use illicit drugs involves much heavier penalties.
Rather than the criminalization of drugs, what is needed, as one woman stated is "dialogue". This dialogue ought to focus the state's interest in prohibiting altered states of consciousness through drug legislation, and in the state's interest in blaming illicit drug use for society's social and economic problems. The continued criminalization of illicit drugs disregards the class, race and gender issues underlying the enactment and enforcement of the Narcotic Control Act. One woman warned:

And that as a society...we should be frightened by it. By what we are doing with so many people. You know, it reminds me of the conservative time in history and how we have...tended to isolate all those that don't fit in.[Carol]

Persecuting women (and men) who wish to alter their consciousness is cruel and counterproductive. Canada must search for more complex answers to its social and economic ills than the criminalization of narcotics and the race, class, and gender biases that underlie this criminalization.
CHAPTER 11 - A FINAL SUMMARY

I. INTRODUCTION

This study suggests that there is, in fact, a diverse group of women who use illicit drugs, in terms of age, race and class. Aside from their status as mothers and their use of illicit drugs, the women interviewed were not homogeneous. The consequences of their illicit drug use were mediated by social status, race, class, gender and social environment, as well as by the legal, social service and medical communities. First Nations and poor women are over-represented in terms of medical intervention, arrest and child apprehension.

The preceding chapters demonstrate how mothers who use illicit drugs are regulated through formal and informal social controls. The legal, medical and social service professions in Canada regulate and punish these mothers. Current drug legislation and policy regarding illicit drug and maternal drug use are based on ideologies concerning "good and bad" drugs, familial ideology and gender-specific roles for mothers.

II. CHAPTER SUMMARIES

The framework for this study is presented in Chapter one. As noted earlier, this study is an integration of critical research on illicit drug use and a feminist analysis of gender, maternal drug use, reproductive autonomy and mothering. The aim is to integrate the literature and to draw from selected historical research in order to provide a social
and political context in which to place the data. This study provides a critical feminist analysis of qualitative data regarding mothers who use illicit drugs in Western Canada, focusing on their opinions on legal and medical and social service policy and regulations that affect their lives.

Chapter two examines the emergence and contributions of the critical perspective, which challenges traditional views about illicit and licit drugs. The pharmacology of drugs and the traditional view that specific drugs are inherently dangerous is explored. It is evident that the origin of Canadian drug legislation was fuelled by moralism, racism, bureaucratic imperatives and economic concerns. Drug treatment, decriminalization, legalization and the concept of social control are examined.

Chapter three outlines the theoretical framework for the thesis by linking the critical perspective on drug use and social control with feminist research on reproductive autonomy and familial ideology. Mothers in Canada who have been identified as illicit drug users have been regulated and punished both formally (through the criminal justice system and Family Court) and informally (when they come into contact with medical and social service agencies).

Chapter four reviews the literature on maternal drug use. The infants of women who use illicit drugs during pregnancy are defined as a challenge to the medical and social service professions. The medical community claims legitimacy and
expertise in treating NAS and maternal health. In response to maternal illicit drug use, the medical community has created regimens of care that focus on managing individual women and their infants.

Illicit drug use is only one of many factors influencing maternal outcomes. Legal drugs - alcohol and tobacco - are more widely used and appear to be more dangerous to infants than illegal drugs. Yet researchers and maternal and infant programs continue to focus on the use of illicit drugs. Like the consequences of illicit drug use for mothers, the labelling of infants as having NAS is mediated by the mothers’ race and class. To date, outside of infant withdrawal, all short- and long-term NAS symptoms are unsubstantiated. Infant withdrawal from prenatal exposure to opiate derivatives ranges from mild to severe, and is unpredictable and transitory.

Women who use illicit drugs are held personally responsible for the outcomes of their pregnancies, regardless of social environments that may negatively affect pregnancy outcomes and mothering in general. The medical community in North America views the ideal pregnancy as drug free, unless the drugs are clinically prescribed. In contrast to the Sunny Hill experiment, programs in England and Scotland strongly suggest that the social and economic environment shapes maternal health. When women are offered nonjudgemental midwifery services and social and economic support, maternal outcomes are similar to those seen in non-drug using mothers.
In Chapter five the research design and methodology are presented. In order to bring out the subjective voices of women, qualitative research methods were chosen for this study. Given the lack of information concerning women's opinions about the institutions that often define and shape their lives, an interview format was selected which facilitates the airing of opinion, rather than one that is centred on life history, ethnography or "career." As noted in Chapter five, feminist research emphasizes the value of subjectivity and "the importance of sex, race and class as factors which together determine the social construction of femaleness" (hooks, 1989, p. 23).

Twenty-eight mothers in Western Canada (British Columbia, Alberta and Saskatchewan) who have used illicit drugs were interviewed. None of the women were contacted at a clinic or in prison. All had been addicted to or dependent on narcotics (opiate derivatives), and/or coca derivatives (cocaine, crack) for more than one year. A snowball sample was used and all of the mothers were assured of confidentiality and anonymity.

In Chapter six the women interviewed discuss their drugs of choice, stigmatization, pregnancy and mothering. Drugs and drug use meant something different for each woman. However, all agreed that aspects of their illicit drug use were positive. And all believed that, because they were mothers, their drug use, and the consequences of their drug use, were different from those of men. The responsibility of caring for
their children shaped their drug use, both positively and negatively.

Pregnancy and birth were challenges for the women interviewed. Many described the negative treatment they received at the time of birth if they were identified as illicit drug users. The social stigma surrounding maternal drug use takes a personal toll on women. Women drug users, and especially mothers who use drugs, are viewed as more deviant than their male counterparts, and this stereotype contributes to their silencing and lack of legitimacy.

Chapter seven provides insight into the NAS in-patient program at Sunny Hill Hospital for Children, in Vancouver, British Columbia, prior to 1992. Infants in this study who were transferred to the NAS program came from families on social assistance and 40 percent were native Indian. Many of the infants transferred to Sunny Hill did not display symptoms of NAS. Rather, they were transferred for economic and social reasons. The medical treatment of NAS infants at Sunny Hill—the darkened rooms, sensory deprivation, the length of stay and lack of contact with families—was atypical.

Data concerning the views of the mothers interviewed and of the founding director of the NAS program at Sunny Hill are presented. The medical care of infants labelled NAS at Sunny Hill was often based on "hunches" and experimental treatment lacking in scientific validity. The subjective beliefs upon which such practices are predicated stem from ideological
assumptions concerning mothering, the family, illicit drug use and poverty.

In the province of British Columbia, social workers and family court judges were informed by Sunny Hill Hospital for Children about the short and long-term problems associated with NAS. Medical testimony from Sunny Hill has been presented in determining the outcomes of custody cases involving infants labelled with NAS. The NAS program at Sunny Hill was the only one of its kind in the province of British Columbia and an opposing opinion was lacking; consequently, medical criteria developed by Sunny Hill were given more weight than other information about the short and long-term effects of NAS. Seven of the ten infants transferred to the NAS program in this study were permanently apprehended by the Ministry of Social Services.

Chapter eight notes that there is no specific social service legislation in Canada that equates maternal drug use with neglect or child abuse. Nevertheless, as demonstrated by the data presented in this study, children have been apprehended by the Ministry of Social Services due to their mother's illicit drug use or past history of illicit drug use, and through being labelled with Neonatal Abstinence Syndrome (NAS). First Nations and poor women are over-represented in terms of child apprehension and the labelling of children as having NAS. These mothers' drug use is perceived as incompatible with good mothering and their children are judged
to be at risk. The interests of child and mother are portrayed as separate from one another. And the interests of the child remain primary to social workers and family court judges, who have little education about cultural differences and family formations outside the nuclear family norm. This has negative consequences for women who come into contact with them. The identification of NAS as a "high-risk" medical problem has led to further intervention by these professionals, with little support for mothers and children.

Illicit drug use does not equal poor parenting any more than licit drug use equals poor parenting. Whether they use illicit drugs or not, women are not traditionally offered extra services until family break-up occurs. When extra services or support from social services are available, they are often judgemental and accompanied by thinly veiled surveillance. Furthermore, social workers often fail to recognize cultural differences and strive to have women reject "the day-to-day support network of friends and replace it with anonymous and distant, paid helpers" (Cain, 1994, p. 39).

In Chapter nine the majority of the women interviewed noted that they had been subjected to inhumane and cruel interventions in drug treatment programs. Drug treatment programs in British Columbia adhere to the philosophy of "addiction as a disease" and persist in using abstinence models, which have proved to be unsuccessful for the majority of drug users. Alternatives to the disease model of addiction
are rare. Contrary to the views of advocates who see pregnancy as a "window of opportunity" for intervention, many women who use illicit drugs are not able to abstain during pregnancy. For this reason, an emphasis on stabilization and normalization would be more helpful than the current emphasis on intervention.

The majority of the women interviewed rejected the disease model of addiction, which requires total abstinence. The chapter presents a wide range of drug policy and treatment options, including more flexible and humane methadone maintenance, heroin maintenance, and the acceptance of drug users and drug use.

Chapter ten presents the views of the women interviewed in relation to drug and drug-related charges, arrest and prison, police surveillance, prostitution and re-entry. The possibilities of decriminalization and legalization are also explored.

Eighty-six percent of the women interviewed stated that Canadian narcotic laws have had negative effects on their lives. Eighty-two percent had been charged with drug, and drug related, offences. Half of the women interviewed participated in drug dealing and a third had engaged in prostitution to supplement their income. However, these activities were not static; a woman's social and economic situation most often predicted what type of activity she might engage in to supplement her income.
The threat of incarceration and separation from children was of major concern to the women interviewed. Their status as mothers, rather than compelling leniency, appeared to compel punitive decisions from parole boards. For many, the fact of having been criminalized continues to affect their lives even after they stabilize and discontinue illicit drugs. In conclusion, the majority of the women interviewed felt that illicit drug use must be decriminalized in Canada.

III. FURTHER RESEARCH

This research contributes to a framework for further critical feminist inquiry into the social control of female drug users, mothering and reproductive autonomy. Further research on the ideological struggles underlying the social control of mothers who use illicit drugs (both familial ideology and illicit drug ideology) will enhance our understanding of the recent phenomena surrounding maternal drug use and the labelling of infants as having NAS.

In order to fully understand the effects of prenatal exposure to illicit drugs, sample sizes need to be large enough to demonstrate clinical significance. A flexible pilot project taking into account regional differences, but otherwise similar to the maternal services offered to women in Glasgow and Liverpool (where nonjudgemental midwifery services and social and economic support are offered), would contribute to knowledge about NAS. Looking outside of the North American perspective on maternal health and NAS will likely be crucial.
in establishing services for women who use illicit drugs, and for their infants. In addition, a comparative study of Vancouver, Glasgow and Liverpool, using interview techniques as well as data regarding birth outcomes, NAS assessment and care, and infant development would be invaluable. It is important to separate the effects of prenatal exposure to specific licit and illicit drugs from those of social and economic factors. Until more solid research is available, policy makers and medical, legal and social service professionals need to suspend judgement concerning mothering and illicit drug use, and examine their urgency to label infants exposed prenatally to illicit drugs as "damaged."

IV. POLICY DIRECTIONS

This study demonstrates how the categorization of drugs as licit or illicit is a social fiction that has no relationship to the dangerousness of the drugs. The continued criminalization of specific drugs sanctions repressive policies on the part of both medical and social service agencies and contributes to negative stereotypes concerning illicit drug use.

The criminalization of drugs and the resulting illegal market have created a situation of increasing criminalization of individuals in Canada. The fabric of society has changed considerably; selective criminalization has undermined civil liberties. Central to the issue of the criminalization of drugs in Canada is the "gradual erosion" of these civil
liberties (Hadaway et al., 1991). Critical researchers claim that illicit drug use, or drug use in itself, is a social problem that cannot be curtailed by harsh laws, incarceration and mandatory drug treatment.

The decriminalization of drugs would eliminate sentencing and prison terms related to drug offences. It would also eliminate the criminalization of millions of Canadians. The practice of sentencing mothers to prison must be reevaluated. Faith (1993) notes the cost in human suffering incurred by women and their children; she suggests that alternatives to incarceration be established. Decriminalization would alleviate the potential stigmatization of millions of people in Canada; no longer would there be an illegal market that generates violence and inflated prices. The rising costs of drug enforcement, court and prison would be avoided (Boyd, 1991). Finally, the taxing of newly decriminalized drugs could contribute to social and health programs, and educational programs, concerning all drug use.

In contrast to the disease/criminal model that prevails in North America, the harm reduction model is gaining some recognition in Canada. This model recognizes that, historically, people have sought to change their consciousness through the use of drugs and that there is a wide response to drug use, ranging from positive to negative. Abstinence is included within the harm reduction model; however, it is only one of many options. Most important, harm reduction recognizes
the illusory line separating licit and illicit drugs, and offers pragmatic options that reduce the harm to both individual and society resulting from drug use and drug laws.

Methadone maintenance is one component of the harm reduction philosophy. In the province of British Columbia, the Ministry of Health guidelines dictate a maximum of 80 milligrams of methadone daily. But this dose is too low for many patients. Obviously, daily doses should be based on an individual assessment of each patient. Doses that are too low discourage narcotic users from attending the methadone programs offered in B.C.

In the U.K., private doctors can prescribe heroin (Judson, 1973; Marks, 1995; Trebach, 1982). Switzerland is currently experimenting with heroin maintenance in eight cities, and the Netherlands and Australia are setting up heroin pilot projects (Nadlemann, 1995). Misinformation and moralism aside, there is no reason why drug users should not have heroin maintenance as one option among many. Possibly the topping up of methadone and other related problems surrounding methadone would cease if drug users had the option of heroin maintenance programs or greater variability in methadone maintenance. If only in terms of reducing the risk of HIV infection, heroin maintenance would be beneficial (Wodak, 1992).

Most important, we must examine why heroin users' requests for legal access to their drug of choice have been
denied since criminalization. It is necessary to grant the illicit drug user adulthood, full rights and some degree of expert status in relation to her own drug use. Only then will drug policy and drug treatment benefit the illicit drug user and society.

It seems only reasonable that people whose lives are affected by policy should be included in decision making. Several user groups have been established in the Netherlands and Australia and they contribute to drug policy-making in their countries (Mol et al., 1992; Wodak, 1992). Currently, the Concerned Citizens' Drug Study and Educational Society in British Columbia has formed a methadone group which advises B.C. physicians regarding methadone policy. If methadone and heroin maintenance are structured to meet the needs of users, human rights infringements and inhumane treatment will cease to be an issue.

User groups have politicized the arena of drug use, moving the mandate from drug treatment to acceptability of drug use and drug users. Their voice and presence continues to shape drug policy and education. It would be helpful for more user groups to be established, supported and heard in Canada. Until then, drug users will continue to be treated as criminals, children and victims.

Abstinence from illicit drugs is considered necessary during pregnancy, and drug treatment is often "mandatory." even when treatment facilities for women and their children
are not available. When programs are available, advocates of drug treatment fail to recognize how women are further monitored and controlled in these programs.

Women who use illicit drugs are perceived to be unfit mothers and their children are judged by social workers to be at risk. As stated earlier, social workers typically have little education about cultural differences, drug use and alternative family formations. The Chief Coroner of B.C. (Cain, 1994) recently presented the concerns of provincial social workers in relation to working with women who use illicit drugs. The social workers' comments reveal their ignorance (although this was not Cain's intention) concerning drug use and mothering, and the lack of services available to women that are not threatening and judgemental. The social workers' underlying message was that all drug use is "a child protection concern" and that, although numerous services are available to women who use illicit drugs, they refuse them (p. 39).

The surveillance of and intervention into the lives of poor women and women of colour is unwarranted. As long as social workers and social policy identify illicit drug use and behaviour outside of traditional female gender roles as deviant, women and children will suffer. What is needed is nonjudgemental social and economic support, not surveillance and punishment.

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The debates surrounding maternal drug use reveal the differences and assumptions underlying two models of health: the medical model and the social model. According to the medical model of health, pregnancy and birth are a medical problem requiring medical intervention in order to decrease risk (Wagner, 1994). The social model of health perceives birth as a biosocial process that is part of the fabric of daily life. The social model of health considers social factors that affect maternal outcomes, such as poverty, poor nutrition and lack of support. Maternal services for women who use illicit drugs should strive to normalize pregnancy and birth and to provide services that meet the needs of the mothers.

Education is another factor that may influence current maternal drug policy. Policy makers and medical, social service and legal professionals need to be exposed to alternative views of illicit drug use and maternal drug use. Women in general need to have access to information concerning maternal drug use that is factual rather than alarmist.

In North America the label NAS is a cultural construct that serves the medical, social service and legal professions by facilitating increased social control of women. "High-risk" labels and legal, medical and social service interventions serve to separate families and to stigmatize and punish both infant and mother. Social attitudes towards mothers who use illicit drugs have implications for all women, especially when
maternal drug use is presented as so "dangerous" that intervention by the state and medical agencies is considered worthy, even when such interventions undermines civil liberties in the most fundamental manner.
APPENDICES
REQUEST FOR ETHICAL APPROVAL OF RESEARCH

The Criminalization of Narcotics and Pregnancy
Susan Boyd
Criminology Ph.D. Thesis
S.F.U.

Utilizing a snowball sample, physicians, drug and alcohol workers, social workers, youth workers, nurses, and adult women who have used illicit narcotics, will be asked if they would like to participate in a one to two hour open-ended interview to discuss their personal opinion concerning:

- medical, and drug and alcohol, treatment for adult women and their newborn infants
- the criminalization of narcotics in Canada
- the effects the law and treatment might have on both women and infants
- the role of social services in relation to child apprehensions

The participants will be informed that they will remain anonymous and their responses will be confidential. Demographic information will also be collected, including race, age, education, and income.

After years of working in the community as a volunteer at women’s centres and community groups I have met many women who have used illicit narcotics. Many of these women have expressed an interest in participating in an interview and have suggested friends who would be interested as well. Furthermore, through family, and friends I have several contacts.
Appendix B
INFORMED CONSENT BY SUBJECTS
TO PARTICIPATE IN A RESEARCH PROJECT

The University and those conducting this project subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort, and safety of subjects. This form and the information it contains are given to you for your own protection and full understanding of the procedures, risks and benefits involved. Your signature on this form will signify that you have received the document described below regarding this project, that you have received an adequate opportunity to consider the information in the document, and that you voluntarily agree to participate in the projects.

Having been asked by Susan Boyd of the School of Criminology of Simon Fraser University to participate in a research project, I have been informed that anything that may identify me during our taped interview will remain confidential. I will not be exposed to the risk of conviction for illicit narcotic use, for all taped interviews will be transcribed, and then destroyed, and my identity will remain anonymous through the use of numbered coding. Any personal description that may identify me will never be revealed. The benefits involved include a better understanding of the social, legal, and political contexts in which decisions are made concerning illicit narcotic use and pregnancy.

I understand the procedures to be used on this project and the personal risks to me in taking part.

I understand that I may withdraw my participation in this experiment at any time.

I also understand that I may register any complaint I might have about the researcher with Neil Boyd, senior supervisor to Susan Boyd, at Simon Fraser School of Criminology.

I agree to participate in an informal taped interview with Susan Boyd.

Name: ___________________________ Witness: ___________________________

Signature: _______________________

Date: ___________________________

A copy of this consent form and a subject feedback form will be provided to you. A copy of the results of this research will also be available if interests.
Having been asked by Susan Boyd of the School of Criminology of Simon Fraser University to participate in a research project, I have been informed that this interview may be used for the purpose of publishing a research paper about women, narcotic use, and pregnancy. I grant my permission for this interview to be used for that purpose. I understand that I may withdraw my participation in this experiment at any time. Parts of this interview may be quoted within my research paper.

I also understand that I may register any complaint I might have about the researcher with Neil Boyd, Senior Supervisor, School of Criminology, S.F.U.

I agree to participate in an informal taped interview with Susan Boyd.

Name:_________________________    Witness:____________________
Signature:_______________________
Date:___________________________

A copy of the results of this research will also be available if requested.
Appendix C
I am doing a research project on how mothers feel about the treatment (medical, social services, legal) that they and their children receive when their children are diagnosed NAS. Would you be interested in doing an informal interview concerning your opinion and experience? All interviews are confidential and anonymous. If you are interested please phone Susan Boyd = 251-1710.

A bit about myself: I am a graduate student at S.F.U. and a mother of two children. Through personal and professional experience I am familiar with the issues surrounding women, narcotic use and pregnancy.
Appendix D
Interview Schedule

(for mothers)

1. How did you get into using drugs (including alcohol)?

2. How has the criminalization of narcotics (the law) effected your life as a mother with children?

3. How did (or does) Social Services effect your life as a mother with children? ie. through intervention or apprehensions

4. Were any of your children labelled NAS or FAS?
   a. Did your child go to Sunnyhill?
   b. Or somewhere else?
   c. How were you and your infant treated?

5. If you had an audience of judges, social workers, police, what would you like to say to them about the law, social services, or just about your life as a mother who used drugs?
6. Do you think drug and alcohol treatment is effective? If so what kind do you think would work? If not, why?

7. Are you more worried about the narcotic laws or social services (apprehension)?
   a. Why?

8. Has it been different for you being a mother who uses drugs, than say a male drug user?

9. Have you been treated differently because of your class, race or ethnicity by professionals in the criminal justice system (police, judges, probation officers, lawyers), social services, or the medical profession?

10. Has there been anything positive about your drug use?

11. What do you see in the future for yourself and your children?

12. Is there anything else that you would like to add?
1. How did you get into working with women who use illicit drugs or their children?

2. Explain the services or program you provide.

3. How are children labelled NAS?
   a. How are they treated?

4. If you had an audience what would you like to say to them about your professional experience working with mothers who use illicit drugs and their children?

5. Do you think your clients are treated differently because of their class, race, or ethnicity by other professionals in the criminal justice system, social services, or the medical profession?

6. Would you like to add anything else?
Appendix E
POTENTIAL LONG TERM NAS PROBLEMS

Impaired growth rate - stunting
Poor movement and coordination
Abnormal muscle tone
Delayed speech
Impaired hearing
Disturbed behaviour
Hyperactivity
Sleep disturbances
Brief attention span
Learning disorders
Aggressiveness
Poor self confidence
Bursts of uncontrollable temper
Difficulty in making and keeping friends
Defective communication skills
Prior to the NAS infant's discharge from Sunny Hill a conference is held. At this time the baby's special needs are explained to the caregivers and to the community professionals involved with the family. When there is a child protection concern it should be understood that the primary worker is the Ministry of Social Services and Housing Worker. The discharge conference is held at Sunny Hill and is attended by: Hospital Pediatrician and Medical Director of the NAS Program, the baby's caregiver(s) (birth parent(s) or therapeutic foster parent(s)), Community Health Nurse, Ministry of Social Services and Housing Social Worker, Sunny Hill Hospital Social Worker and Sunny Hill's NAS Clinic Nurse-Coordinator. Other health care professionals, support workers and extended family attend as indicated. Usually, the discharge conference is not held when the baby is going to the home of an experienced therapeutic foster mother. If a discharge conference is not held, the clinic nurse-coordinator contacts the community health nurse to inform her about the baby's needs. In such an instance, it must be ascertained that the baby's social worker is familiar with the risks and needs of that infant, and of any special arrangements needed by the foster parent.
1. **Sudden Infant Death Syndrome**

Reports show that the NAS infant is at very high risk for SIDS, 6 - 10 times the incidence in non-drug populations, i.e. 2% of drug exposed babies, and over 14% if cocaine has been involved. An effort to reduce the likelihood remains for controlled studies to substantiate the impressions of SIDS researchers. They feel that the baby needs to sleep in the same place with the same time patterns and that her/his sleeping schedule should be protected. She/he should not be in a room where someone has been smoking as this may increase her/his risk for SIDS. Anyone who needs to smoke should do it outside. The increased risk for SIDS lasts until the baby is about eleven months of age in the group of drug-exposed infants. [In the NAS program, the baby's immunization schedule is delayed until after six months of age.] Jan/32: This is presently under review; please check with NAS Medical Director re: scheduling of immunization as immunization is due, i.e. at age 2 months, etc.

2. **Poor Resistance to Infection**

The NAS infant has poor resistance to infection so it is important for her/him to avoid contact with people who do not need to be near her/him. She/he should not go to shopping malls, churches, health clinics or anywhere there may be unnecessary contacts. It is fine to go outdoors as long as crowds are avoided.

3. **Medications**

NAS infants should not have any medication unless prescribed by a doctor. Babies cough for a reason so nothing should be done that would suppress the cough as babies can't cope with their secretions and can die of obstruction. A humidifier may be helpful when mucus is troublesome. An infant nasal aspirator may be helpful in removing obstructive mucus in the nostrils. The caregiver should have a thermometer and know how to use it. If the baby has a fever, an alcohol free preparation of acetaminophen may be given, such as Panadol. Fluoride drops may be given as per Vancouver Health Department Policy.
4. **Screaming**

The NAS infant may become a "screamer". This type of behavior can be very frustrating because the high-pitched crying can go on for hours no matter what the caregiver may do to try to soothe the baby. Swaddling the baby seems to provide comfort and may prevent the aimless thrashing about that often accompanies irritability. Protection from noise and light stimulation may also decrease irritability. It is most important that the caregiver have someone available for relief when screaming causes extreme frustration.

5. **Secondary Withdrawal**

The NAS infant may experience a second wave of withdrawal anytime up to six months of age. The symptoms of withdrawal may mimic those of potentially life-threatening diseases. For example, stiffening and arching may be indicative of meningitis, fast breathing may be a sign of pneumonia and diarrhea could be a sign of infective gastroenteritis. If any of these symptoms occurs, it is imperative that the baby receive immediate expert medical attention. Please see your family physician/pediatrician, or go to B.C. Children's Emergency Department.

6. **Community Health Nurse Follow Up**

It is important for the Community Health Nurse to visit in the baby's home. Part of her assessment will be to measure the baby's weight, length, and head circumference to monitor the baby's growth along the growth chart. Short term growth failure may be the only indicator of impending SIDS or a silent otitis media, which is more likely in NAS. A missed otitis media in an NAS baby may go on to:

a) meningitis

b) chronic ear and/or hearing problems

SIDS risk extends for a longer time in NAS infants and may be amenable to some intervention, e.g. restricted activity. Any necessary attendance at the Health Clinic for immunizations, should not be at peak hours.

7. **Feeding**

As per Public Health General Pediatric Requirements.
8. **Developmental Follow Up**

At four months of age, the NAS infant should have her/his first developmental assessment. This is done by one of the specialized therapists at Sunny Hill Hospital. The purpose is to monitor and identify developmental problems as soon as possible and to recommend appropriate intervention.

9. **Medical Follow Up**

Infant in the NAS Program at Sunny Hill Hospital should be seen according to the protocol of the NAS Follow-up Clinic at Sunny Hill Hospital. Visits will be followed as close to developmental assessments as possible for the first year of life. This appointment is held in the NAS Clinic at Sunny Hill. At the Community Health Nurse's discretion, a duplicate copy of the NAS flowsheet will be provided for the caregiver to take to the infant's family doctor/pediatrician in the community.
### SUNNY HILL HOSPITAL FOR CHILDREN
### NEONATAL ABSTINENCE SYNDROME FLOW SHEET

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<tr>
<th>Convulsions</th>
<th>Muscle Tone</th>
<th>Tremors</th>
<th>Irritability</th>
<th>Crying</th>
<th>Sucking</th>
<th>Stools</th>
<th>Skin Abrasions</th>
<th>Sneezing</th>
<th>Yawning</th>
<th>Diaphoresis</th>
<th>Vomiting</th>
<th>Temperature</th>
<th>Heart Rate</th>
<th>Respirations</th>
<th>Formula type and intake:</th>
<th>Visitors</th>
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**Guide to Withdrawal Scoring**

**CONVULSIONS**
- 0. None
- 1. Present

**MUSCLE TONE**
- 0. Normal
- 1. Hypotonic
- 2. Hypertonic

**TREMORS**
- 0. None
- 1. Minimal when handled
- 2. Marked when undisturbed

**IRRITABILITY**
- 0. None
- 1. Minimal when disturbed
- 2. Marked when undisturbed

**CRYING**
- 0. Normal
- 1. Excessive - unconsolable after 15 min.
- 2. Continuous High Pitched

**SUCKING**
- 0. Normal
- 1. Incoordinate
- 2. Weak
- 3. Steps early
- 4. Absent or almost

**YAWNING**
- 0. None
- 1. Present

**DIAPHORESIS**
- 0. None
- 1. Present

**STOOLS**
- S = seedy
- W = watery
- E = explosive
- P = pasty

**VOMITING**
- 0. None
- 1. Present - chart amount and time relative to feeding

**SKIN ABRASIONS**
- 0. None
- 1. Present - describe in progress notes

**SNEEZING**
- 0. None
- 1. Present

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LIVERPOOL NEONATAL DRUG WITHDRAWAL CHART

Name: .......................  Casenote No: .......  DOB: ......  Gestation: ..........

All infants of drug misusers must have observations started from birth. Observations made post-feed. Severe symptoms - please tick (✓) if present.

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1. Convulsions

2. Tremors when undisturbed. Non-stop high-pitched cry. Sleeps < 1 hr after good feed. (All must be present to score)

3. Watery stools or projectile vomiting or requirements of tube feeds

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1. Convulsions

2. Tremors when undisturbed. Non-stop high-pitched cry. Sleeps < 1 hr after good feed. (All must be present to score)

3. Watery stools or projectile vomiting or requirements of tube feeds

Signature:

LIVERPOOL WOMEN'S HOSPITAL NHS TRUST

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LIVERPOOL NEONATAL DRUG WITHDRAWAL CHART

INSTRUCTIONS FOR TREATMENT

Minor Symptoms need not be recorded.

(Minor symptoms listed for differentiation purpose - tremors when disturbed, respiration's > 60 per minute, pyrexia of unknown origin, sweating, frequent yawning, sneezing/nasal stuffiness, poor feeding/regurgitation, loose stools). If treatment of the 3 severe symptoms not judged clinically necessary, then reasons must be recorded in casenotes.

Treatment: 0.04mg/kg morphine sulphate orally. Begin treatment 4 hourly ("treatment level 5"). Then reduce level of treatment every 24 hours if severe symptoms not present as follows:

0.04mg/kg morphine sulphate 6 hourly ("treatment level 4")
0.04mg/kg morphine sulphate 8 hourly ("treatment level 3")
0.04mg/kg morphine sulphate 12 hourly ("treatment level 2")
0.04mg/kg morphine sulphate daily ("treatment level 1")

If severe symptoms still present do not reduce level.

If severe symptoms persist on 4 hourly morphine ("treatment level 5") discuss with senior paediatrician the possibility of increasing dose of morphine or adding other medication.

LIVERPOOL WOMEN'S HOSPITAL NHS TRUST
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Appendix G
Participant #1 comes from a working class background. She is 38 years of age, of European heritage and a single parent of one child. She notes that she grew up during a time when the boundaries around who was using drugs shifted. However, her first drugs used were licit drugs, both alcohol and tobacco at age 13. By the time she was 14 she was using marijuana and L.S.D. Shortly thereafter, she began to experiment with barbiturates and heroin. A close friend was using heroin and she tried it out of curiosity. After using several times she noticed that she felt "normal" for the first time. As an adolescent she had often felt confused and alienated, heroin appeared to ease her discomfort. For two years she continued to experiment with heroin though she never became addicted. Sensing that she did not want to be ruled by "any" drug, she stopped using heroin before she turned twenty.

At that time she only engaged in casual use of psychedelic drugs. When she was 21 she enrolled in university. She and her partner had a child and she abstained from all illicit and licit drugs. When her child was two she was prescribed Valium and Percocet for a medical ailment. She became dependent and eventually addicted to both Valium and Percocet. Within a year she was using heroin and other narcotics. Stopping was more difficult due to her schedule at school and her responsibilities as a mother. She sold drugs in order to subsidize her income. She attempted methadone maintenance but was unable to cease using other illicit drugs and eventually left the program. She tried to detox several times, and entered two drug treatment centres. The separation from her child was difficult. Each time she left treatment she continued to use illicit drugs.

After four years she was able to cease all drug use on her own, withdrawing at home with the help of friends. She went on to finish her university requirements. She has been working as a health professional for several years. She has been drug free for 10 years.

Participant #2 is a 36 year old women of European heritage. She comes from a middle-class background, though she has been on income assistance for many years. Her first introduction to drugs was prescription drugs when she was 13. She also experimented with psychedelic drugs. She lived with her family and finished highschool and then entered university. When she was 21 she used cocaine and believes that she developed a dependence to cocaine very quickly.

She was in a series of abusive relationships with men and her dependence on cocaine escalated. She had
three children and was on social assistance. The police were often called to the house to break-up fights between her partner and herself. Social services intervened and she entered a recovery house. She ended up returning to the father of her children for economic reasons and began using cocaine again. She eventually lost custody of all three of her children. At that time her drug use escalated and she began to engage in prostitution.

Several years later she became pregnant again with a man who did not use illicit drugs. Her child was apprehended at birth and diagnosed with NAS. The infant was transferred to the NAS program at Sunny Hill. Her infant remained there for five months. During that time she stabilized her cocaine use, not abstaining, but using less frequently. Her infant was eventually returned to her because her husband was working full-time and had no history of illicit drug use. Nevertheless, two years later social services still maintains an open file (child protection concern). She still uses cocaine occasionally.

Participant #3 is a young twenty-two year old woman of European heritage. She was raised in rural British Columbia in a middle-class family. She is currently on social assistance and is a single-parent of one child. She began to use licit drugs when she was 12, and marijuana when she was 13. She described herself as rebellious and wanting more freedom. When she was 13 she ran away from home and starting working as a prostitute in Edmonton. After several months she returned home. She did not get along with her parents and continued to run away, but knew that she could always return home. So it was like a holiday, go out and do drugs...slumming it, and then return home.

When she was 14, she stole money from her parents and they charged her. She received probation. By the end of the year she breached her probation twice and received six months in juvenile corrections. For several years she compiled a lengthy juvenile record consisting of several breeches and again served time in corrections. At that time she also began to use cocaine and engaged in prostitution to finance her drug use. For several years this remained her lifestyle until she became pregnant at the age of twenty. She ceased using cocaine with the support of a women's group and delivered a healthy baby. Her child was not labelled NAS. Currently, she is abstaining from drugs and attending full-time college with some social assistance.
Participant #4 is a young native Indian woman from the prairie provinces. She is 30 years of age and the mother of two children. She is a single-mother. She used only licit drugs and marijuana when she was younger. She did not use cocaine until she was twenty-five years old, which occurred after the break-up of her first marriage. Her husband gained custody of their child, and she moved to Vancouver and continued to use cocaine. She was arrested several times for possession and soliciting.

She became pregnant and tried to receive information about maternal drug use and the affect on her developing child. She visited a doctor and was told there was nothing he could do until the infant was born. She continued to search for help and during her seventh month of pregnancy she found a supportive doctor who explained the possible affects of maternal drug use. She entered the hospital and detoxed. She stayed in the hospital for three weeks. Her child was born and there were no complications. Her infant was not labelled NAS. At the time of the interview she was no longer using cocaine. She is currently attending a full-time college course with the support of social assistance.

Participant #5 is a twenty-eight year old native Indian woman from northern British Columbia. She was raised by her aunt and began drinking when she was 16. In grade 11 she dropped out of school and moved to Vancouver. She met her partner there and moved to the east coast with him and worked for several months as a waitress. Her boyfriend abandoned her and she lost her job and found herself without any financial support or friends. She eventually ended up staying with some people in an abandoned home. She met a man there who took her under his wing. He was selling cocaine in small amounts and she began to help him sell. Several months passed before she tried cocaine and then she used occasionally. After two years her cocaine use escalated and she became dependent. She left the east coast and returned to Vancouver without her boyfriend.

In Vancouver she met her partner and became pregnant. She gave birth to a full term infant. There was no evidence of NAS at birth. When her child was two months old she went to a party leaving her infant with a friend. She did not return till the next morning and her friend had called the Ministry of Social Services. Her infant was apprehended while she was gone. During the first week at the foster home, her infant was brought to the hospital because he was choking and stopped breathing. She explained that the foster mother left her child laying down with a bottle in his mouth unattended. The infant was observed at Grace Hospital in Vancouver and then transferred to the NAS in-patient program at
Sunny Hill. Her infant was there for six weeks although he did not exhibit any signs of NAS or any other health problems. Her infant was eventually released to foster care, however, and she gained custody several months later.

For the last three years she has been bringing her child to Sunny Hill for follow-up appointment. These have been difficult for both her and her child. She believed that many of the games and activities that her child was tested with were foreign to her and she would leave Sunny Hill feeling inadequate as a parent. She is currently on social assistance due to health problems unrelated to her illicit drug use.

Participant #5 is a forty-seven year old woman of European heritage. She was introduced to illicit drugs when she was attending university; marijuana was her drug of choice. A group of friends were experimenting with cocaine and heroin and she tried heroin and liked it. Her boyfriend at that time was beginning to use quite heavily. They married and eventually had two children. Her husband became more and more involved in criminal activities to finance their growing narcotic dependence. He was arrested several times and spent a number of years incarcerated. Nevertheless, they were able to maintain a comfortable middle-class lifestyle.

The last time her husband was incarcerated, she tried methadone maintenance at a clinic. Methadone maintenance was problematic as the rules were rigid and it was difficult to maintain employment due to the daily pick-up times and mandatory counselling sessions. She did stabilize and stopped using illicit drugs. She returned to university and completed her M.A. degree. She eventually found a private doctor to prescribe methadone and her career has flourished. She has been on legal methadone for 12 years and currently teaches at a community college.
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