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'KEEPING MUM':

A QUALITATIVE STUDY OF WOMEN DRUG USERS' EXPERIENCE OF PRESERVING MOTHERHOOD IN DUBLIN

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B.Soc.Sc

A THESIS SUBMITTED IN FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF PH.D

SCHOOL OF SOCIAL WORK AND SOCIAL POLICY

FACULTY OF SOCIAL AND HUMAN SCIENCES,

UNIVERSITY OF DUBLIN

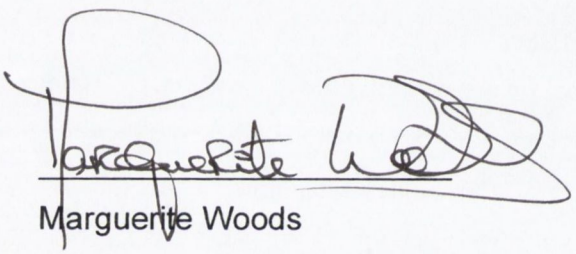
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Marguerite Woods

Summary

According to academic accounts, it is not uncommon for women who use illicit drugs to be culturally portrayed in negative stereotypical terms as 'unfeminine', 'unclean' and 'immoral'. Nowhere is this more evident than when a woman is both a drug user and a mother, when the stereotype is expanded to describe a person who invariably gives priority to her drug use rather than to her children. Where many studies purport to present objective clinical data which demonstrate that maternal drug use is incompatible with good parenting, the present study - while taking account of professional views on this topic - privileges the lived motherhood experience of women drug users who struggle to combine parenting with drug use. This study is about women, drug use and motherhood in Dublin.

Drawing on qualitative research methods, such as in-depth and semi-structured interviewing, focus groups and participant observation and informed by a feminist perspective, this study aims to elicit the views and opinions of women affected by illicit drug use, as well as professional workers, counsellors, social workers, nurses, doctors and others, who impact on their lives. Consultation with many of the more than 300 participants occurred at every stage of the process - proposal, design, data collection, analysis and presentation. Throughout the fieldwork period, reflexive strategies were employed and the data generation and analysis were guided by grounded theory principles and practices, such as theoretical sampling, constant comparison and memo writing.

The thesis explores how women experience the everyday eventualities of being a mother, being a drug user and combining the doing of both, against a backdrop of generalised social exclusion and family adversity. It is concerned both with how being a mother and having children impacts on drug use and with how drug use impacts on the identity, status and role of motherhood. It also seeks to examine how women experience the judgements, reactions and interventions of others and how they perceive the role of service providers and their impact on their lives. Additionally, it examines professional workers' perceptions of women drug users as mothers.

A grounded theory emerged from the data, a trajectory of drug-involved motherhood, charting their early journeys from observing, rehearsing and anticipating motherhood in childhood and teenage years to becoming drug users and mothers and beyond. Their early achievement of dual status - both as mothers and drug users - strongly influenced how they perceived themselves and how they were perceived by others. The women tended to define themselves primarily in terms of motherhood, while for many professionals the 'master status' was that of drug user.

The findings describe the experiences of the women at varying stages of both their motherhood and drug-using careers, revealing their aspirations to Good Mother status and charting their interactions with key actors such as their children, partners, families, drug treatment providers and social workers. These accounts highlight the conflicting discourses arising about motherhood. Key moments, actions and processes such as performing, defending, justifying and preserving motherhood are illustrated, while the actions of family members and professional workers in challenging, watching and monitoring motherhood are also described. The experiences of women who succeeded in preserving their identity, role and status are related, as are those of women who experienced the interruption or termination of their motherhood role, having lost some or all of their children to the care of others.

However, whether drug free, currently using or methadone maintained, all the women expressed anxieties and regret about their dual status and identities. While many asserted their competence as parents, they simultaneously were concerned about others' perceptions of them as mothers and their mothering performance. With few exceptions and regardless of the impact of their drug use, they expressed feelings of guilt and remorse about being drug users or their drug history, about their children, their shame, their undeserving nature, and often talked in terms of reform, change and improvement in order to become better women, mothers, partners and daughters. They also expressed feelings of inadequacy, lack of confidence and insecurity about their motherhood role. Concerns about children, the impact of their drug use and lifestyles on children and child welfare were often expressed candidly by the women. While frequently reluctant to describe themselves as good mothers because of their drug use, many believed that there was no question about their fitness to parent. Without exception, they would prefer to be non-drug-using mothers. However, drug free women with a distant history of use also identified their experiences of stigma and the ignominy of a past career in drug use.

Workers too expressed concerns on occasion. A small minority seemingly perceived drug use and parenting as incompatible and mutually exclusive activities. Others, the vast majority, believed that drug use *per se* does not necessarily impact on the ability to be a 'good enough' parent. Despite their ambivalence about methadone, most workers expressed a preference that their women clients either be stabilised on this substitute drug or be drug free rather than using street drugs. A typology of workers, based on their approach to and optimism with regard to outcomes for women drug users as mothers, is offered.

A range of experiences of drug-involved mothers, as custodial mothers, non-custodial mothers and mothers caring for some but not all of their children, is discussed. Many of those who lost custody of their children appeared to become further immersed in drug taking, often reportedly as a grief reaction or a coping strategy. Others, however, worked towards retrieving or recovering their motherhood role, attempting to prove through becoming drug free or stable that they may in the future be good parents, often with little success. In very exceptional circumstances motherhood was partially restored or retrieved. A range of living arrangements, care and separation experiences of the children of the drug-using mothers in this study is also identified.

Throughout, one of the principal findings relates to the impact structural factors have on the women's ability to parent and parent in a way defined appropriate currently by child welfare services and society at large. The study describes how the women constructed motherhood, did mothering, managed mothering and negotiated motherhood against a backdrop of social and contextual factors such as drug use, poverty (in the main predating drug use), educational disadvantage, illness, lack of social, community and family support, lack of childcare facilities and general adversity, all of which impacted on the motherhood role. However, overwhelmingly the impact of homelessness, insecure accommodation, long term residency in either hostel or bed and breakfast accommodation or the threat of any of these was reportedly the key reason for many children of drug-using mothers living in the care of other family members or foster carers.

A key narrative of preserving motherhood is identified, highlighting the women's preoccupation with concealing their drug-using status or at least minimising their involvement with drug use in order to preserve their role as mothers. This belief, however, is anathema to the notion of harm reduction or the reduction of drug-related harm, particularly during pregnancy or parenting, where women may need medical attention, advice and intervention or social and family support.

In the light of the living arrangements of mothers and children, their experiences and the emergence of the trajectory of drug-involved motherhood, this thesis concludes that women drug users are different from other mothers in society. Drug-using mothers have an identity which is ambiguous and precarious, and which is largely determined by their interactions with others, particularly service providers and by efforts to perform, justify, defend and preserve their mothering role. A woman's master status as 'drug user' pertains always and subordinates the motherhood status. One trajectory, an overarching process or key narrative, predominates that is, the struggle to preserve motherhood – Keeping Mum.

THIS STUDY IS DEDICATED TO

ALL THE 'FALLEN ANGELS'

IN PARTICULAR TO THE MEMORY OF

ESTHER, WHOSE UNUSUAL EXPERIENCE AS 'FOSTER MOTHER' INSPIRED IT, EVEN THOUGH SHE WAS LONG GONE BY THE TIME IT COMMENCED

&

LYDIA, LINDA, ANN MARIE, ANNE & ROSE WHO GAVE SO MUCH TO THIS PROJECT BUT WHO DID NOT LIVE TO SEE THE FINAL PRODUCT

Acknowledgements

This thesis has been a part of my life for a lengthy period. I wish to record the enormous debt of gratitude owed to several people.

Firstly, I would like to sincerely thank my colleague, Dr. Helen Buckley, for her supervision throughout this research endeavour. I think that we have both survived!

I would like to acknowledge all my colleagues in the School of Social Work and Social Policy in Trinity College Dublin, including the Head of School, Professor Robbie Gilligan, the Director of Postgraduate Teaching & Learning, Dr. Eoin O'Sullivan and the Director of Undergraduate Teaching and Learning, Ruth Torode. My Addiction Studies colleagues are also due thanks. Pam Isaacson offered moral support, encouragement and technical advice. Dr. Shane Butler was a great support and offered advice throughout, but especially in the final days.

A large number of my Diploma, MSc in Drug and Alcohol Policy, Social Work and TAP students had to endure my testing out all sorts of ideas and theories on them during lectures and the feedback I received was invaluable and much appreciated. The staff of the Library was wonderfully patient and resourceful in finding texts through inter-library loans and Silvia Stewart faithfully transcribed some of the lengthy interviews.

Several people were just there with support, words of wisdom and acts of kindness from time to time, such as fellow researchers - Barry Cullen, Mary Cunningham, Ann Fitzgibbon, Cliona Hannon, Stephanie Holt, Tony Jordan, Dr. Helen Kelly, Gloria Kirwan, Dr. Paula Mayock, Vivienne O'Brien, Erna O'Connor, Aoife O'Driscoll, Carmel O'Sullivan, Dr. Maryann Valiulis, Dr. Trish Walsh (all of Trinity College Dublin) and Professor Julian Buchanan (NEWI, Wales) and Dr. Sarah Dalal Goode (Winchester).

Beyond the walls of the Ivory Tower, I had some phenomenal support and assistance. I wish to acknowledge the generosity and commitment of all the workers in the field who participated and demonstrated such interest in this project. I also wish to thank family members who gave so willingly of their time and views. While many individuals and agencies helped in various ways, the SAOL Project let me spend six months in their company and programme and was as empowering and welcoming to me as a researcher, as it has been to women drug users over its twelve year existence.

Some of my friends kept me going and listened to my ramblings so to Rose, Maria and Trish – a very special thank you.

I would like to thank my parents - my mother, Audrey, for her support and considerable editorial eye and attention to detail, my father, Frank, for his ongoing encouragement and belief - and my sister, Valerie, for her invaluable advice in the final moments. I must also mention John, David and my niece and goddaughter, Fauve Madeleine, born the same year as this thesis!

I am most grateful for the support and understanding of my partner, Ray McGrath. Throughout the years of this study he has listened patiently and discussed every idea that ever occurred to me. Despite the lengthy illness and tragic loss of his daughter, Karin, in December 2006, he has been behind me every step of the way in these final months. I thank him for being there, for feeding me (and the cat), plying me with cups of tea and coffee and taking me away for walks in the park when all seemed insurmountable.

Finally, and above all, the women who participated, sharing many difficult experiences and reminiscences of motherhood, are to be commended for having had the courage to do so. It was on occasion a painful task. Some did not live to see the final product and this is the source of enormous regret and grief for me. I want to thank them. This thesis, for what it is worth, is dedicated to you all.

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Show me something more
Than the wolf at the door
All the begging in the cold
To keep the wolf from the fold
Show me something more
Than an honest girl turned thief or whore
Under African sun or Dublin rain
Necessities remain the same

("Angel", Tracey Thorn/Ben Watt – Everything But the Girl, Love Not Money, WEA Records Ltd, 1985)

CHAPTER ONE

WOMEN, ILLICIT DRUG USE AND MOTHERHOOD IN DUBLIN: AN INTRODUCTION

> We are all born of women. We have all had mothers even though we may have had very different experiences of motherhood. This alone qualifies us all to speak on the subject. (Kennedy, 2004: 7)

This study is about women, illicit drug use and motherhood. Where other studies purport to present objective findings of professionals – psychiatrists, psychologists, social workers, nurses and others – on the way in which maternal drug use disrupts parenting and leads to childhood maladjustment, this qualitative study is primarily aimed at presenting the views of drug-using women themselves on how they experience motherhood. These subjective accounts of parenting will, therefore, include both detailed discussions of how the research participants themselves understand and value parenting, as well as their descriptions of how they negotiate with potentially powerful agents of social control whose professional ideology predisposes them to the view that drug use is incompatible with good parenting. The accounts of professional workers in the drug treatment, medical, nursing, community work and social work fields in Dublin are also related. This introductory chapter contextualises the study.

Women's illicit drug use is rarely mentioned without a concern expressed for the foetuses, infants and children of those involved. The importance of motherhood in the lives of women drug users has been acknowledged in research endeavours (Butler & Woods, 1992; Friedman & Alicea, 2001; Klee *et al.*, 2002; Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993), some of which are notable ethnographies offering a picture of women's involvement in parenting in the context of their drug careers. Studies of women drug users' experiences of motherhood as the central theme are few and far between (Baker & Carson, 1999; Goode, 1999; Hardesty & Black, 1999).

Several studies, incorporating interactionist, resistance and feminist perspectives, have challenged how society views women drug users (Boyd, 1999, 2004; Ettorre, 1992; Friedman & Alicea, 2001; Maher, 1997; Rosenbaum, 1981a; Taylor, 1993). Following this tradition, this research poses questions about how society views women drug users as mothers by accessing and keeping central the women's accounts of motherhood experiences. These accounts and those of professional workers, sometimes differing but rarely diametrically opposed, provide the basis for this study, focusing on the women's interactions with their children, partners, families as well as those within drug treatment and social work services, services that are often primarily concerned about their needs precisely because they are involved in parenting.

The research aims to

- document women drug users' experiences of motherhood and parenting
- explore their interactions with drug treatment and social work services
- document professional workers' perceptions of women drug users' experience of motherhood and competency with regard to parenting
- examine the dilemmas for both drugs workers and social workers in this regard.

Methodology

Drawing on a qualitative, inductive and feminist perspective using research methods, such as in-depth interviewing, focus groups and participant observation, this study aspires to create a knowledge base and contribute to debate about women drug users, motherhood and parenting. It also seeks to consider the implications for service delivery to women drug users, their partners, families and children, provide impetus for the improvement of service provision to these groups and inform the development of services.

Conducted in an area in Dublin characterised by poverty, unemployment and transgenerational educational disadvantage, the fieldwork period was lengthy (January 1999 - June 2002), constant contact with many participants was maintained, and member checking and discussion during analysis post fieldwork was continued until late 2005. Participation and consultation with a large number of participants occurred at every stage of the process - proposal, design, data collection, analysis and presentation.

During fieldwork 205 women with varied drug and motherhood histories and 100 professional workers participated in interviews, focus group discussions and conversations during observation at various sites. In addition, regular discussions with eight of the women's adult children and with many male partners and family members took place.

What distinguishes this study from several others concerned with drug use and motherhood is the heterogeneity and diversity of the groups of participants involved in terms of profile and experience, the lengthy period spent in the field, gathering, analysing and verifying data and the insider knowledge and prior work history of the researcher, all issues that will be discussed presently in the chapter devoted to methodological concerns. Although many women participants have experienced difficulties and problems with parenting, some of which have limited or indeed terminated their full-time role as parents, this study endeavours to explore this issue with women drug users in general. It did not draw its respondents from the records of courts, from child protection registers or even solely from drug treatment agencies as other studies have done (Baker & Carson, 1999; Chaffin *et al.*, 1996; Famularo *et al.*, 1992; Hampton *et al.*, 1998; Kelleher *et al.*, 1994; Murphy *et al.*, 1991), although some of the women interviewed were indeed in contact with such agencies. The women participants were recruited variously through participant observation, snowballing/chain referral

strategies and in several cases through one drug project. The motivation for carrying out such a study arose from observing the increasing local interest in both drug users as parents and the children of drug-using parents during my time as a professional worker in the drug treatment field. My observations of the gendered nature of parenting or primary care-giving and the reality that it is generally drug-using women rather than men who care for children or come to the attention of services as parents were also motivating factors. Furthermore, my observation of the lack of concern with the needs of women drug users as mothers, other than during pregnancy, and the lack of interest in the impact of children and motherhood on women led me to focus on their lived experience of motherhood.

Previous experience also usefully informed the proposing of research questions, articulated as follows:

- What do the participants tell us about their lives as mothers with a history of drug use?
- What do professional workers tell us about women drug users' experience as mothers?
- What interactions occur between one group regarded as problematic (because they are mothers who use or have used drugs) and another that provides professional care, treatment and support to them?
- Are there any underlying tensions, differences or contradictions in the women's accounts of their experience of motherhood and professional workers' perceptions of their experience of motherhood?

Study Rationale

The point of departure is the dearth of women-oriented and feminist research or practitioner concern with regard to women, drug use and motherhood specifically. In the Irish and international contexts, tensions exist between alternating images of women drug users as fit parents on one hand and unfit and incapable on the other. These tensions mirror the chasm between the traditional, classical models of responding to drug use and the newer public health 'harm reduction' model, recently described as postmodern in perspective (Ettorre, 2000, 2004), often offered as a pragmatic compromise to the problems arising in the traditional models.

Broadly speaking, traditional models and policies of responding to problematic alcohol and drug use have drawn on either a treat or punish perspective (Butler, 1991, 2002a; Campbell, 2000; Gusfield, 1996; McDonald, 1994; Reinarman & Levine, 2004). The treatment response emerges out of a perspective which views addiction and drug use as a disease or disorder requiring commitment to abstinence for recovery. The punishment perspective views drug use and addiction as an aberration or moral failure requiring punishment with a view to rehabilitating those who have offended and deterring those who have not yet offended.

Harm reduction models, often without acknowledgement, draw on a Victorian public health model of promoting hygiene and combatting infectious diseases. This perspective found its way into the

drug treatment arena due to drug users' vulnerability to infectious diseases, such as Hepatitis A, B, C and HIV, as a result of the sharing of injecting equipment. The Victorian era's obsession with social and moral hygiene is replicated in this model and it has been suggested that the social construction of risk and perceptions of risk are paramount. Rhodes (1997: 58) pointed out that epidemiological knowledge and understanding about risk and its reduction 'tells us as much about moral danger as it does biological danger'.

Debates have abounded as to the definition of harm reduction, one humorous account (Wodak & Saunders, 1995: 269) suggesting that when used by many academics, researchers, practitioners and proponents of different treatment perspectives, it simply means what they choose it to mean. The terms 'harm reduction', 'harm minimisation and risk reduction', the 'reduction or minimisation of drug related harm' are terms used interchangeably finding their way into almost every publication or mission statement with regard to treatment. However, it is patently clear that the way this term is being used may differ significantly across the field. Wodak and Saunders argued that 'the ambiguity of the term (harm minimisation) adds to the confusion of an area already complicated by lack of terminological clarity and excessive emotional fervour' (1995: 269). They further suggested that the term 'reduction of harm' can

> be used to cover any measure which decreases the negative consequences of drug use... "Harm reduction" could then be reserved for those specific measures which prevent the baleful consequences of drug use without setting out to achieve this objective by interfering with drug consumption.

Over time the definition of harm reduction has broadened to include the reduction of individual, social, economic, cultural and even political harm (IHRA, 2000). Nevertheless, not all accept this model as a benign and benevolent alternative to traditional models concerned with addiction. Using Foulcauldian perspectives, some recent critiques of harm reduction have drawn attention to this model as medical, strictly regulated and concerned with surveillance (Keane, 2003; Miller, 2001).

However, somewhere between these classical and postmodern perspectives, women users of illicit drugs live their lives, often bearing, rearing and parenting children, while others endure separation from their children through loss of custody to the care of others. Although several studies have focused on women substance users of alcohol, licit drugs and illicit drugs together (Goode, 1999; Raine, 2001), thereby conflating the experiences of three very different groups, Ettorre's argument that different substances merit separate analysis (1992: 2) suggests that a study focusing on the experiences of mothers who use illicit drugs is timely. There is a need to differentiate between the users of licit and illicit drugs due to the differences in terms of stigma, marginalisation and the social acceptability of the two groups.

Research carried out in Dublin among heroin users predominantly (Butler & Woods, 1992; Dunne, 1995; O'Neill, 1994; Shea, 1992) clearly demonstrated the importance of parenting in women drug users' lives, highlighting their involvement in caring for their partners and children often to the

detriment of their own health and well being. Anecdotal evidence also suggests that many women presenting to services put forward their status as parents as that which is central to their lives, echoing findings among women in other locations (Rosenbaum, 1981a; Taylor, 1993).

There now exist many texts concerned with women's drug use and several with regard to women drug users' involvement with parenting. Nevertheless, women drug users' everyday and lived experience of motherhood has often been ignored in favour of a problem focused fitness to parent perspective. Women's voices are rarely heard at length in this context, the voices of the 'experts' largely informing the discourse with regard to women drug users and parenting. There has been increasing attention by paediatricians, psychiatrists, psychologists, nurses, social workers and childcare personnel to the issue of pregnancy and the health of babies exposed to drugs antenatally. It has been suggested that this tends towards an overly medicalised perspective concerning the nursing management and care of the neonate (Boyd, 1999; Farrell, 2001; Hogan, 1997, 1998; Murphy, 1992; Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993; Woods, 2000a). Less attention is paid to the wider experience of women outside of the reproductive or pregnancy experience.

The social and psychological needs of the children of drug-using parents have excited significant attention during the period this study has been carried out in drug, social work and psychological literature internationally, as has the issue of child protection (ACMD, 2003; Adams, 1999; Barnard, 1999; Bates *et al.*, 1999; Buchanan & Corby, 2005; Buchanan & Young, 2002; Buckley *et al.*, 2006; Forrester, 2000, 2004; Forrester & Harwin, 2004, 2006; Harbin & Murphy, 2000; Keen & Alison, 2001; Klee & Jackson, 1998; Klee *et al.*, 1998; Klee *et al.*, 2002; Kroll, 2004; Kroll & Taylor, 2000, 2003; McKeganey *et al.*, 2002; Tunnard, 2002a). In Ireland increasing interest in the needs of the children of drug-using parents and child welfare or protection responses to these children has been evident (Bowden, 1997a; Clarke, 1994; Hogan, 1997, 1998, 2003; Hogan & Higgins, 2001a, 2001b; Murphy & Hogan, 1999; Shanks, 2000; Woods, 1994, 2000a; Woods & Daly, 1995). Although studies are often gender neutral in their titles and content, the words 'parenting' and 'mothering' are almost always used interchangeably. Furthermore, most studies concentrate on how parents, parenting capacity or parental drug use impacts on the lives of children and rarely explore how the presence of children and the motherhood role impacts on the women's lives.

Without such a focus, there is a danger of throwing the woman rather than the baby 'out with the bathwater' (Woods, 2000a: 275). Some studies have looked at how children impact on their drug-using mothers either generally or in the context of their drug-using or treatment careers (Baker & Carson, 1999; Boyd, 1999; Colten, 1982; Goode, 1994, 1999; Hardesty & Black, 1999; Rosenbaum, 1981a; Taylor, 1993). However, the social and lived experience of drug-using mothers has been underdocumented and little sociological work has explored women's experience of motherhood beyond their parenting of small babies (Boyd, 1996, 1999; Murphy, 1992; Taylor, 1993; Woods, 1994).

By virtue of their involvement in illicit activities - drug use, crime and 'deviant' behaviour - women drug users' role as mother is often brought into the public sphere where there is much concern and scrutiny. Research examining this experience and the meaning of both drug use and parenting in their daily lives is limited. This study, focusing on women, drug use and motherhood and the social and political context in which it takes place, is an attempt to fill this gap in the literature. This study, then, represents the first qualitative account of women drug users' experience of motherhood in Dublin. It also represents the first study concerned with the experiences, perceptions and dilemmas of professional workers responding to this group in the Irish context and it is one of a small number of studies dealing with those issues in an international context. Based on the women's accounts and on those of the professional workers, who interact with them, it explores this experience in the Irish context.

Definition of terms

As mentioned above, 'excessive emotional fervour' (Wodak & Saunders, 1995: 269) tends to characterise this field. Throughout this study, in order to avoid the use of emotive language, the term 'drug user' is employed to describe those who participated. However, even the use of this term in itself may present difficulties because in fact this research does not aim to study the experience of all women drug users as parents but of those who use or have used heroin and other opiates and are or have been generally defined by themselves and others as problematic drug users.[1] In addition, it is used generically as a category describing membership of a certain group whereas in fact some women participants were at the time using drugs, others were methadone maintained and several were drug free. However, the designation, 'drug user', is chosen, rather than 'addict', 'misuser' or 'abuser', in order to avoid the stigma and judgements associated with such terms. As the World Health Organisation (1981) has asserted

> "abuse" and "misuse" are unsatisfactory concepts within a scientific approach. Because the terms involve value judgements they are impossible to define in such a way that they are appropriate for different drugs in different contexts.

The term 'drug use' refers to illicit drug use and will be used throughout except in specific quotations where the language of another author is used. The children of drug-using mothers/parents are described as such because of their mothers/parents' involvement in the use of illicit drugs.

Scope of Study

While focusing on the drug-using mother could be described as a limitation in terms of looking at the issue of parenting generally, this study is concerned with women drug users' lived experience of motherhood. The observation that few studies have focused on parenting by fathers who are drug users has been made (Hogan, 1998) and there has been a call to address the issue of substance use and fathering and turn attention to 'adding poppa to the research agenda'

[1] No 'diagnostic' category, scale or measure of 'addiction severity', for example, has been used in this study. Qualitative attention has been given to the participants' definitions and reports.

(McMahon & Rounsaville, 2002: 1109). However, this is not the task of the present study. As Berridge (2002: 1117) aptly noted in her response to this call, '[m]en's role in substance abuse should be recognized, whether as risk group, fathers or vectors. But let us not write women out of the picture'. It has also been observed that the actions of drug-using fathers elicit far less concern than those of drug-using mothers (Friedman & Alicea, 2001).

Research has demonstrated that when women drug users have a relationship it is likely to be with a drug-using man (Barnard, 1993; *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*, 1996; Kearney & Ibbetson, 1991; Klee, 1996; McKeganey & Barnard, 1992a; Sargent, 1992; Taylor, 1993). Other studies have described many women drug users as lone parents while some women have been reported as co-parenting with a male partner (Klee & Jackson, 1998; Taylor, 1993). Despite this, several studies in the Irish context have examined the needs of children of drug-using parents with limited if no reference to gender differences in primary care-giving (CSET, 2002; Hogan, 1997; Hogan & Higgins, 2001a). The gender neutral term 'parenting' is not clear about who does what in terms of the work of parenting. While motherhood, the status and identity, had been attained by virtue of having given birth and being birth mothers, the women in the study were not just parents, in most cases as mothers they were or had been the primary care-giving parent. Despite changes in women's roles in society, parenting is increasingly defined as a female domain (Boyd, 1999; Buckley, 1998a, 1998b, 2003; Featherstone, 1999, 2004; Friedman & Alicea, 2001; Gillies, 2006; Hogan, 1998; Kearney, 1994; McMahon, 1995; Scourfield, 2001, 2003).

As mentioned above, much previous research focused on pregnancy and the nursing and management of babies, while other studies have focused on the experience of children in the 4-12 age group (Hogan 1997; Hogan & Higgins, 2001a) and several have discussed parenting in a more generic and less age specific sense (Bowden, 1997a; Clarke, 1994; Kearney 1994; Woods, 1994). The 26 women who participated in interviews represent a broad age range (18 – 44 years at the time of interview) as do their 68 children (6 months to 24 years). This broadens the scope of issues over time addressed by the study allowing a retrospective and contemporaneous glance at mothering experiences across the women's and their children's lifetimes. This differs from the focus of a range of other sociological studies that have studied pregnancy and the parenting of small babies and its relationship to or with their drug use (Boyd, 1999; Kearney, 1993; Klee & Jackson, 1998; Klee *et al.*, 1996; Lewis *et al.*, 1995; Murphy, 1992; Murphy & Rosenbaum, 1999).

It is important to note that this study is not concerned about whether women drug users are good mothers, bad mothers, mediocre or indifferent mothers. Nor is it a study of the impacts or effects on children of being parented by a drug-using mother. These types of studies have been and continue to be carried out elsewhere. Although this project at points touches on the impact of parental substance use on children, particularly in the literature review, and there are some findings in this regard, the overall aim is to explore women's involvement in and experiences of

motherhood. It explores how they experience the everyday eventualities of being a mother, being a drug user and combining the doing of both. It also seeks to explore how women experience the identity and status of being a mother and drug user, how they experience the judgements, reactions and interventions of others and how others' interventions and judgements impact upon their lives. It is concerned with how being a mother and having children impacts on their drug use and how their drug use impacts on their identity, status and role of motherhood. It also aims to explore the views and experiences of professional workers in this regard and examine the collision between different worlds, groups and worldviews.

Heeding the caveats offered by some researchers of women's drug use (Ettorre, 1992; Perry, 1979), this study seeks to keep the impact of structural factors central and to avoid presenting an 'asocial' or 'desocialised' analysis. Therefore, issues of gender, class, educational disadvantage, unemployment and poverty, both predating and consequent to drug use, inform this study and fall within its scope. Attention is paid throughout to the environment in which the women live their lives, use drugs, and parent. In order to avoid over privileging the drug issue, the notion of the drug, set and setting (Zinberg, 1984) is kept in mind throughout.

Background and context

This section examines the social context in which the women live their lives and which is crucial to their experience of motherhood. The position of women and motherhood in Irish society is briefly described before moving on to examine Irish policy and treatment debates, illicit drug use in Dublin and the limited statistical data available about women drug users' parenting in Dublin.

Women and Irish Society

In a 1992 publication (Butler & Woods, 1992) based on qualitative research about Dublin women's experiences of drug use and HIV infection, the authors located the research and its findings within the socio-cultural context. The study concluded that the women participants experienced a range of constraints, institutional, cultural and Constitutional, which were experienced by Irish women in general. This study provides an interesting point of departure for this discussion of women in Irish society as it examined the experience of women drug users with HIV in the context of Irish women's experience in general. A later study of the cultural constraints on the delivery of HIV prevention in Ireland echoed these findings (Smyth, 1998).

The ideology of motherhood as it has prevailed in Irish society historically demonstrates how women's roles as child rearers, bearers and the custodians of the moral education of children, providing the link between the church and the individual, have been determined (Inglis, 1998). A number of key texts have documented the changes in Irish women's lives that have occurred over the last thirty years (Beale, 1986; Byrne & Leonard, 1997; Connolly, 2002; Inglis, 1998; Kennedy, 2004; Mahon, 1995; O'Connor, 1998), while others have focused on the changing role of men and fatherhood (Clare, 2000; McKeown *et al.*, 1998).

Indeed the Irish Constitution's view of the role of women is specific with regard to motherhood. Article 41.2 of Bunreacht na hÉireann states:

> *1. In particular, the State recognises that by her life within the home, woman gives to the State a support without which the common good cannot be achieved.*
>
> *2. The State shall, therefore, endeavour to ensure that mothers shall not be obliged by economic necessity to engage in labour to the neglect of their duties.*

As O'Connor (1998: 91) argued, 'being female in Irish society is very closely tied up with the bearing of children'. The words 'mother' and 'woman' are almost everywhere interchangeable in the Irish Constitution in articles 41.2.1 and 41.2.2 (Rowley, 1989). Specifically with regard to drug-using women, Butler and Woods (1992: 65) noted this interlinking of motherhood and womanhood, whereby a professional worker interviewed stated that '[t]he pram with the child is a badge of something achieved'. The authors also argued that women drug users had much in common with other Irish women, perhaps more in common than with their male drug-using counterparts. The significance of the transition to motherhood was echoed in the findings of another more recent Dublin study of young people's involvement with drug taking which identified the most striking life event or transition as that related to pregnancy and the birth of children (Mayock, 2003: 118).

A collection of papers on motherhood has presented a 'not a very pleasant picture of the construction and control of the institution of motherhood in Ireland' (Kennedy, 2004: 7). It identified as others have done that 'while women are often confined and constrained by their reproductive role by a patriarchal State and Church, they are often unsupported in that role' (2004: 7).

The 'moral monopoly' of the Catholic Church, its position above criticism, its involvement in education and its impact on the development of social policy during the 20th century cannot be underestimated (Butler & Mayock, 2005; Butler & Woods, 1992; Inglis, 1998; Lee, 1989; Whyte, 1980). Other forces, such as emigration, have been suggested to have major impacts too on the development and conservatism of Irish society (Corcoran, 1993; Smyth, 1998). The dominance of Catholic social teaching brought about a situation where until very recently the role of the state was affected by the notion of subsidiarity and it was only in the last analysis that it could legitimately interfere in the lives of the Catholics (Butler & Woods, 1992; Smyth, 1998; Whyte, 1980). The rejection of the 'Mother and Child Scheme', a proposed programme for the provision of free antenatal and maternity care for all women, by conservative and Catholic forces in Irish society in 1951 is perhaps one of the most well-known and documented examples of this theory in practice (Inglis, 1998; Whyte, 1980). The thrust of this conservatism has been directed to the economic control of women or the control of sexuality, particularly female sexuality. The 1950s and 1960s, with the advent of Sean Lemass' less protectionist economic policies, witnessed increasing economic prosperity and the commencement of accelerated social change at almost every level in

society (Butler, 1991, 2002a). However, it should be noted that those communities least likely to benefit from this economic development and prosperity were precisely those that later were impacted upon by intravenous drug use and the advent of HIV (Butler, 1991; Smyth, 1998).

Legislative changes in the 1970s commenced with the enactment of the Civil Service (Employment and Married Women) Act 1973 and the removal of the 'Marriage Bar', which had prevented married women from working in the Civil Service, Health Boards and Local Authorities after marriage. The following year saw the introduction of the Anti-Discrimination (Pay) Act and in 1976 two pieces of legislation, the Family Home Protection Act and the Family Law (Maintenance of Children and Spouses) Act, were enacted. In 1977 the Employment Equality Act and the Unfair Dismissals Act arrived on the scene. The Council for the Status of Women, which later became the National Women's Council, was established in 1973 and the ongoing development of a range of pressure and advocacy groups, such as AIM, Women's Aid, Dublin Well Woman Centre, Open Line Counselling, Dublin Rape Crisis Centre and others led to the emergence of new services for women. Consequently the focus on issues such as family law, sexuality and reproductive rights increased.

The status of illegitimacy prevailed until its abolition by the enactment of the Status of Children Act in 1987 and contraception was illegal until 1979[2] and then only available on a limited basis until after amendments in 1985 and 1992. Abortion was and continues to be illegal[3], while

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[2] In 1972 the McGee case highlighted that a citizen had the right to import for his or her own personal use contraceptives from another jurisdiction. The following year, 1973, witnessed the spectacle of the then Taioseach leading a Fine Gael and Labour coalition, Liam Cosgrave, crossing the floor of the Dail to vote with the Opposition against a Bill proposed by his own party to legalise contraception. Although it was widely practiced and a great number of family planning centres flourished, contraception continued to be illegal until 1979 when it was legalised for *bona fide* family planning purposes and with the introduction of legislation married people could now access contraceptives, even non-medical contraceptives such as condoms and spermicides, only with a doctor's prescription. There were further amendments in 1985 and in 1992 the situation changed totally. Indeed it would appear that the advent of HIV woke the nation up to the importance of the condom as a prophylactic with regard to infection.

[3] Abortion was and continues to be legally prohibited in the Republic of Ireland under the 1861 Offences against the State Act, which makes performing, attempting or assisting in an abortion punishable by penal life sentence. Additionally the 1967 Abortion Act in Britain does not extend to Northern Ireland. It follows that a large number of Irish women travel abroad to Britain in order to terminate their pregnancies. The recent reports from the Crisis Pregnancy Agency (Press Release 19th June 2007 – www.crisispregnancyagency.ie) suggested that for the sixth year in a row there has been a decrease in the numbers of women giving Irish addresses in British abortion clinics. The number of women has decreased by 1,631 since 2001. A total of 5,042 Irish women gave Irish addresses in 2006 and the abortion rate or the number of abortions per 1000 women aged between 15 and 44 years has decreased from 7.5 in 2001 to 5.2 in 2006.
Following a referendum in September 1983 the Constitution, which had already prohibited abortion, was amended in an effort to ensure that it would never be legalised. A clause equating the life of the mother with the 'unborn child' was written into the Constitution. It stated that the State

> acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect and as far as practicable by its laws to defend and vindicate that right.
>
> Article 40.3.3

Significantly the interpretation of this wording was to cause major changes in 1992. During 1985 and 1986 'pro-life' groups protested almost daily outside organisations such as the Dublin Well Woman Centre (personal recollection; Connolly 2002), which provided a range of women's health services including pregnancy counselling on all options, and Open Line Counselling, which provided a pregnancy counselling service. In 1985, the Society For The Protection of the Unborn Child (SPUC) sought an interlocutory injunction against

homosexuality was only decriminalised in 1993.[4] The Irish electorate in a 1986 referendum rejected divorce. However, less than ten years later in 1995, a second referendum permitting divorce was passed. Legislation was later enacted.

The position of the Catholic Church has been challenged over the past twenty-five years, its dominance diminishing (Butler & Mayock, 2005; Butler & Woods, 1992; Coakley, 2004). In the 1990s, it has been challenged considerably with the emergence of a number of issues which highlighted the Church's role and the State's complicity in a variety of occurrences - forced foreign adoptions, the Magdalene laundries, religious orders' involvement in the provision of residential care and the implication of priests and nuns in cases of sexual, physical and institutional abuse that have received extensive media exposure (Butler & Mayock, 2005; Coakley, 2004; Ferns Report, 2005; O'Sullivan, 2002; Raftery & O'Sullivan, 1999; Torode & O'Sullivan, 1999)

While many legal and social changes have taken place, research attention has turned to a broader range of experiences, issues and concerns which pertain to Irish women now (Byrne & Leonard,

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these agencies arguing that non-directive counselling was counter to the constitutional guarantee afforded to the unborn by Article 40.3.3. This led to the High Court Case against them in October 1986. The Court finally delivered its judgement, known as the Hamilton Judgement in December 1986. This decision effectively demanded that non-directive counselling by these agencies, or their servants and agents, cease. The Centres appealed the decision to the Supreme Court and the hearing took place in 1988. On this occasion the Supreme Court upheld the decision of the High Court and 'perpetually restrained' the agencies and their employees from assisting pregnant women in terms of information or referral. On this occasion in March 1988 costs were awarded against the two agencies. They appealed to the European Court where they later won their case in 1992. In October 1992, following the post Hamilton Judgement Appeals by the agencies concerned to the European Court of Human Rights and Justice, the European Court found that the order of the Irish courts was in breach of the Human Rights Convention's information rights clause. In 1992 a young girl who had been raped was restrained from travelling to Britain to procure an abortion (Connolly, 2002). The Attorney General successfully sought a High Court injunction in this regard. This was appealed to the Supreme Court, which lifted the injunction. However, in its judgement it found that Article 40.3.3 actually permitted abortion in Ireland if the woman's health was endangered by her threatened suicide (Connolly, 2002). This was followed by an outcry about this case, known as the X case, and a further referendum took place in November 1992 in which the majority of the electorate supported the right to information and the right to travel, which changed the position significantly. However, a third amendment was rejected. This stated that

> It shall be unlawful to terminate the life of the unborn unless such termination is necessary to save the life, as distinct from the health, of the mother where there is an illness or disorder of the mother giving rise to a real or substantive risk to her life, not being the risk of self-destruction.

Throughout the 1990s, although legislation impacting on the travel and information issues was enacted, legislation on the substantive issue was not introduced. The Regulation of Information Act, stipulating that information on abortion services can only be provided in the context of counselling was introduced in 1995. The Department of Health and Children commissioned a study on crisis pregnancy, published in 1998 (Mahon *et al.*, 1998), and a Green Paper on abortion, published in 1999. 'Pro-Life' groups commenced agitating again, their aim to initiate another referendum, with renewed vehemence and, as some would suggest, more aggressive tactics than heretofore. Following the introduction of the Human Life and Pregnancy Bill in 2001, the establishment of a statutory body dealing with the issues of crisis pregnancy in 2002, the Fianna Fail/Progressive Democrats coalition government initiated a referendum which took place on March 6, 2002. Despite Government and mainstream 'pro-life' organisations' support to carry the referendum, other political parties and strange bedfellows including 'women's right to choose' groups and conservative 'pro-life' campaigners, opposed this and the referendum was not carried. Several cases such as the C case (November, 1997) and the D case (May, 2007) have also come to court highlighting the controversial and divisive nature of the situation. However, the law as it stands is that following the X case.

[4] after years of campaigning by Gay rights organisations and the Norris case in the European Court of Human Rights, which established that, the Irish Government was in contravention of the Court.

1997; Kennedy, 2004; McCashin, 1996; O'Connor, 1998). These suggest the heterogeneity of Irish women as a social grouping. Studies of the feminisation of poverty (Daly, 1989; Cantillon, 1997), of the gendered nature of the social welfare system (Cook & McCashin, 1997; McCashin, 1996, 2004), of women's experience of health issues (Conlon, 1999; Wiley & Merriman, 1996) highlight the persistence of poverty and deprivation among women. Indeed it has been suggested by a European Commission study that 23% of Irish women are at risk of living in poverty (European Commission, 2005; *The Irish Times*, February 15th, 2005: 10). Social welfare dependence is high while women attempt to fulfill their mothering obligations as defined by the Constitution.

Women's health has received some significant attention in terms of research and policy documents during the 1990s and since 2000 (Women's Health Council, 2007). However, discussion of women's substance use tends to focus on alcohol, tobacco and tranquillisers as these are obviously much more widespread in Irish society than either experimental or recreational use of illicit drugs or problematic opiate use. Most documents ignore or pay little attention to the use of illicit drugs, and the health of women drug users, prisoners or of those working in prostitution, while acknowledged, remain low on the lists of priorities. The women's documents tend to shy away from illicit drug use and associated issues while the drugs documents, as shall be seen, despite several aspirational statements tend to comment briefly on concerns pertaining to women.

Commentators appear to either suggest that women's role in Irish society has changed significantly or not at all over the last thirty years (O'Connor, 1998: 1). While the clauses in the 1937 Constitution remain, and are currently attracting some attention from the Irish Human Rights Commission, some recent census data reveal figures suggesting significant changes with regard to the position of women, fertility, and family structure in Irish society (CSO, 2007a, 2007b, 2007c). An 8.5% increase in population to 4,239,000 since the last census in 2002 in the twenty-six counties was reported. They also reported falling fertility in that within a generation the average number of children per woman has declined from 3.5 to 2.2. Irish families have decreased from an average of 2.2 children per family in 1986 to 1.4 in 2006. There has been a 23% increase in the numbers of lone parent families to almost 190,000. In addition a 50% increase in the numbers of cohabiting couples to 121,800 was recorded, now amounting to 11.6% of all family units. The numbers of same sex couples, one third of whom were female, have increased from 1,300 in 2002 to 2,090 in 2006. Women's labour force participation increased from 29.7% in 1981 to 52.8% in 2006 (CSO, 2007c). The percentage of women describing their status as 'looking after home/family' has fallen significantly over the twenty-five years from 54.9% in 1981 to 21.8% in 2006. However, there were 161,000 unpaid carers in 2006, just under 5% of the population, 62% of whom were women, most of them in their forties and fifties. Women too are more likely to be involved in voluntary work activity. These recent census data illustrate that there have been significant changes in Irish women's fertility, family status and work participation over the past twenty-five years alongside significant legal, social and cultural changes discussed earlier.

Illicit Drug Use in Ireland – Prevalence and Policy

In Ireland there has been an increase in the use of illicit drugs, including opiates, over the last thirty years. The emergence of problematic drug use in Dublin City and the advent of HIV were unprecedented and necessitated the development of health and social responses to those affected. Against this earlier backdrop of conservatism, underdevelopment and poverty (Butler & Woods, 1992; Smyth, 1998) and the eventual emergence of a so-called 'Celtic Tiger' economy in the late 1990s (Allen, 2000; Garvin, 2004; Sweeney, 1998), a series of policies with regard to drug use have evolved (Butler & Mayock, 2005).

There has never been any sustained policy debate on illicit drugs here but practice has evolved pragmatically, especially post-HIV, towards a greater use of harm reduction strategies. Prior to the advent of AIDS/HIV in Ireland, services generally espoused a total abstinence perspective (Butler, 1991, 1997, 2002a; Butler & Woods, 1992; Cullen, 1994; Loughran, 1998; O'Gorman, 1998). The advent of HIV during the 1980s led to the adoption of more pragmatic public health and harm reduction perspectives and impacted considerably on the development of services, including harm reduction and low threshold responses. Elsewhere (Butler, 1991; 2002a), a detailed analysis has charted the development of Irish drug policy and different periods of policy making. Highlighting their key characteristics, it is suggested that first there was an era of commitment to an abstinence model at a period of time where there were few users, followed by a heroin 'epidemic' during which there was a grudging acceptance of some limited harm reduction perspectives. The final period refers to the period during which the discovery of the presence of HIV in the drug-using community and concerns about the possible spread into the 'general population' led to the acceptance of methadone maintenance as a treatment option and other harm reduction measures.

Prior to the 1980s, there were effectively two agencies responding to those with drug problems in Dublin, the National Drug Treatment Centre Board and Coolmine Therapeutic Community. However, eventually these clinical and drug free focused regimes were supplemented by a range of social and harm reduction perspectives, pioneered by a low threshold voluntary organisation, the Ana Liffey Drug Project established in 1982 and later adopted by the Merchants' Quay Project on its establishment in 1989. This paved the way for a shift in the paradigms underlying drug treatment policies and led to the adoption by the Eastern Health Board and other agencies of an approach focused on reducing the harm associated with drug use. A low key and initially unpublicised needle exchange programme opened its doors in May 1989.

In May 1991, the publication of the *Government Strategy to Prevent Drug Misuse* by the National Coordinating Committee on Drug Abuse, the establishment of the National AIDS Strategy Committee at the end of 1991 and the publication of its first strategy document in April 1992 followed. These further laid the groundwork for the shifts in drug policy and treatment paradigms, the latter strategy document recommending the establishment of satellite drug treatment clinics. Consequently the drug treatment system developed with a strong HIV prevention agenda during

the early to mid 1990s.

Significant further expansion in services was witnessed from 1996. In the 1996 report of the Health Research Board (HRB), 23 agencies returned information about their clientele while in 1997, this had increased to 30 agencies. In 2000, 156 agencies, including some general practitioners, returned information. In the same year, a review of the development of Health Board Addiction Services reported that there were now 50 drug treatment centres whereas in 1995 there had been three and that these services represented some of the finest in Europe (Farrell *et al.*, 2000).

This development arose for a number of reasons. A number of rapid changes occurred following the community unrest and significant upheaval in 1996 after the killings of an HIV affected drug user and of the journalist Veronica Guerin in April and June respectively (Butler, 2002b; Woods, 2000a). The establishment of the Ministerial Task Force on Measures to Reduce the Demand for Drugs ensued.

It speedily published its first report in October 1996, having called for submissions from interested parties during the summer.[5] Significantly the *First Ministerial Report on Measures to Reduce the Demand for Drugs*, otherwise known as the 'Rabitte Report' (Butler, 2002a, In Press), was the first official, published document in which an Irish governmental committee explicitly and unequivocally stated that problematic drug use, particularly opiate use, and social exclusion, specifically poverty, were inextricably related. While numerous studies had made these claims[6], these evident connections were not publicly or officially acknowledged until the 1996 publication (Butler, 1991, 1997, 2002a).

As a result of this acknowledgement, different strategies to respond to drug problems in communities were proposed. Local Drug Task Forces were established in Dublin, Cork and later in Limerick and there was a commitment to a considerable amount of funding, the development of subcommittees in Task Force areas focusing on treatment, education and prevention, rehabilitation and supply reduction and the development of services. The thrust of Irish drug policy formulation which had hitherto been the HIV epidemic, particularly among injecting drug users (Butler, 1991, 1997, 2002a), now appeared to be informed by concerns with poverty, community impact, social exclusion and 'public nuisance' issues. Concerns with both demand and supply reduction were evident.

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[5] In a forthcoming article, reviewing the ten years since the 'Rabitte' Report, Butler describes how this document was produced in a three month period and contrasts it in both presentation and policy impact with the National Alcohol Policy which was glossy, took six years to produce and had little impact on policy.

[6] Successive reports pointed to the link between poverty or socio-economic deprivation and drug use. As early as 1983, the 'Bradshaw Report' (Dean *et al.*, 1983) contended that there was evidence of a strong link between the two in the Irish case (Butler, 1991, 2002a), as did much research since. Significantly, the report of the National Anti-Poverty Strategy (1997), while it had received submissions from a range of drug agencies, did not focus on the issue of drug use other than to highlight it briefly as an issue for many communities which were experiencing poverty, marginalisation and multi-layered disadvantage.

The establishment of the Criminal Assets Bureau (The Criminal Assets Bureau Act, 1996) was undertaken and it has worked zealously to confiscate assets and wealth accumulated as a result of drug dealing, trafficking and other activities. A commitment to the notion of estate management in local communities gave rise to the passing of a piece of legislation, entitled the Housing (Miscellaneous Provisions) Act 1997[7], which has reportedly affected drug users, particularly women drug users, and their children significantly (Cox & Lawless, 1999; Memery & Kerrins, 1999; Woods, 2000a). In 1998, the Methadone Protocol[8] was introduced by a Statutory Instrument. This ensured the further localised and sectorised nature of treatment, introduced new controls and obliged drug users to return to their communities of origin for treatment (Butler, 2002c).

In May 2001, a National Drugs Strategy 2001 – 2008 (Department of Tourism, Sport and Recreation, 2001) entitled *Building on Experience* was launched, outlining policy and projected outcomes for measures during the period and a mid-term review of the strategy was carried out in 2004. These documents described Irish drug policy as one of harm reduction, explicitly mentioned by the Taoiseach, Bertie Ahern as he launched the 2001 document. However, recent discussions of drug policy suggest that the policy and strategy is 'a shaky edifice' and that ideological issues remain unresolved (Butler, In Press). Moreover developments currently tend to be driven by drug market and crime concerns, and public order issues (Cassin & O'Mahony, 2006; Connolly, 2005, 2006; O'Mahony, 2004).

Drug users continue to be a highly stigmatised and excluded group, as evidenced by several studies of Irish people's attitudes and beliefs (Bryan *et al.*, 2000; McGréil, 1996).[9] Despite significant changes in drug policy, a stated commitment to harm reduction, an increase in the delivery of drug treatment services and reduction in crime, drug users remain marginalised and socially excluded within Irish society, their complex needs still often unacknowledged and

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[7] The Housing (Miscellaneous Provisions) Act 1997 allows for the eviction of tenants from local authority or corporation housing if involved in 'antisocial behaviour' or in the interests of 'good estate management'. Anti-social behaviour includes 'the manufacture, production, preparation, importation, exportation, sale, supply, possession for the purposes of sale or supply, or distribution of a controlled drug (within the meaning of the Misuse of Drugs Acts, 1997 and 1984)' or 'any behaviour which causes or is likely to cause any significant or persistent danger, injury, damage, loss or fear to any person living, working or otherwise lawfully in or in the vicinity of a house provided by a housing authority under the Housing Acts 1966 to 1997, or a housing estate in which the house is situated and, without prejudice to the foregoing, includes violence, threats, intimidation, coercion, harassment or serious obstruction of any person'. It appears that very little evidence is required to invoke this Act.

[8] The Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations, colloquially known as the 'Methadone Protocol' came into effect in Ireland on October 1, 1998. It effectively institutionalised and regulated General Practitioner methadone prescribing. In the context of fieldwork during the research described in this thesis, many women raised concerns about the fact that they were compelled to attend general practitioners or treatment services in their own communities of origin rather than a centralised service or a general practitioner of their choice.

[9] A report outlining the findings of a survey of drug-related knowledge, attitudes and beliefs in Ireland revealed that social avoidance and fear of drug users were high and that sympathy for this group was relatively low among respondents (Bryan *et al.*, 2000). More than half the respondents expressed the view that 'those with a drug problem had only themselves to blame'. However, while there was almost unanimous support for drug treatment, 65% of respondents believed that it should be offered only to those drug users who ultimately strive to become drug free. Another study suggested that 43% of respondents would deny drug users citizenship, concluding that drug users 'are being pushed out of society' (McGréil, 1996:353).

unaddressed in a coordinated and comprehensive manner (Cox & McVerry, 2006). Currently the development of services appears to be influenced by 'public nuisance' issues and a necessity to reassure communities about resolutions to problem drug use and criminal activity.

Drug Users – A Head Count?

The number of drug users living in Dublin is uncertain. However, various estimates have been made over the years. One, a Garda Research project, 'identified with certainty' from data bases that 4,105 individuals were involved in 'hard drug' use (Keogh, 1997). Another attempt to measure the prevalence of opiate use in Dublin, a capture-recapture estimate based on methadone treatment lists, acute hospital discharges and Garda data, estimated that there were 13,461 users in Dublin in 1996 (Comiskey, 1998; Comiskey & Barry, 2001). A third study focused on the north-east inner-city and offered an estimate of 1,657 opiate users (Coveney *et al.*, 1999). More recently, another study presented the first national estimates, indicating that there were 14,158 and 14,452 opiate users in the Republic of Ireland in 2000 and 2001 respectively. Estimates of opiate users in Dublin were 12,268 for 2000 and 12,456 for 2001 (Kelly *et al.*, 2003).

Treated populations are easier to access. Between 1990 and 1994 the HRB gathered data about those receiving treatment in the Greater Dublin Area (O'Hare & O'Brien, 1992, 1993; O'Higgins, 1996; O'Higgins & O'Brien, 1994, 1995). Between 1995 and 2002 (the last year for which there are published returns for the eastern region), the National Drug Treatment Reporting System (NDTRS) has gathered information nationally. The later reports identified the concentration of treated drug use in the eastern region (Kelly, Long *et al.*, 2005; Kelly, Lynn *et al.*, 2005; Long, Lynn & Kelly, 2005; Moran *et al.*, 1997; O'Brien *et al.*, 2000; O'Brien *et al.*, 2002; O'Brien *et al.*, 2003; O'Higgins & Duff, 1997). In 1990, 2,037 cases were reported in the Greater Dublin Area (O'Hare & O'Brien, 1992) while in 2002, 5,476 cases were reported in the eastern regions out of a national total of 7,845 (Long, Lynn & Kelly, 2005). Over the 13 year period then, the majority were young, unemployed men who started using drugs during their teens, had left school before the official school leaving age of 15 years and lived with their families of origin. The central treatment list, a national service for the recording and processing of all those on methadone, recorded the total number of 8,962 clients during 2005 (DTCB, 2006).

With regard to women's representation in the statistics, interesting insights may be extrapolated from the studies. In Keogh's (1997) survey the majority or 84 % (3467) of the identified drug users were male, unemployed, single and living at home, indicating that 16% of drug users or 638 individuals were women, 615 of whom were opiate users. Comiskey's study (1998) estimated that 3,117, a little more than 23% of the estimated 13,461 of drug users in Dublin in 1996, were women. However, later estimates suggested that of 12,456 individuals using drugs in Dublin in 2001, 4,178 (33.5%) were women (Kelly *et al.*, 2003). Interestingly there was a statistically significant increase in the number of young women between 25 and 34 years using opiates between the first and second prevalence studies.

In the early 1990s, as numbers coming forward for treatment increased the proportion of women in treatment fell, a fact referred to in the *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* in 1996. Treatment figures identified percentages of women treated as high as 26.3% of 2,037 in 1990 to a low of 20.7% of 2,954 in 1994 (O'Higgins, 1996). However, later HRB reports suggested that between 1995 and 2000 percentages ranged from as low as 22% of 3,593 individuals in Dublin in 1995 (O'Higgins & Duff, 1997) to 33% of 5,380 in 1999 in the Eastern Health Board Region (O'Brien *et al.*, 2002). While between 1990 and 1994 the male female ratio stood at four to one (4:1) with the ratio approaching five to one (5:1) in 1994 (O'Higgins, 1996), since then women's uptake of treatment has increased significantly. Generally the treatment statistics between 1998 and 2002 (Kelly *et al.*, 2005; Long, Lynn & Kelly, 2005) revealed that approximately 67% of those in treatment were male and 33% female. One possible explanation for these increases could be that women or girls are being pushed or pulled earlier into treatment. A study examining the profile of children less than 18 years of age receiving treatment from addiction centres in Dublin between 1990 and 1999 found that, when compared to adults in treatment, they were more likely to be female (Smyth & O'Brien, 2004). It was also noted in the Annual Report of the Drug Treatment Centre Board in Dublin that the ratio of males to females receiving treatment was 'circa 2:1' and that the male/female ratio in 19 year olds and under had reversed from 2:1 in 2004 to 1:2 in 2005 (DTCB, 2006: 9).

Some have suggested that women drug users are less likely to seek treatment or come to the attention of treatment centres (Ettorre, 1992; Henderson, 1990; O'Hare & O'Brien, 1992; Parker *et al.*, 1988; Sargent, 1992; Taylor, 1993; Woods, 1992). However, in Dublin, until recently, proportionately the percentage of women in treatment seemed to be higher than the percentage of women in the overall population of drug users. Therefore it may be reasonable to suggest that in the past women have indeed come forward for treatment, either willingly or because of pressure from other quarters to do so, and once they came to the attention of services they appeared to be prioritised and retained in services (Cox *et al.*, 2006). These and other findings may lead to speculation that women's involvement in drug use and crime as well as their involvement in and uptake of treatment differ to their male counterparts. In addition, treatment responses to women may be different.

Irish studies have shown varying results with regard to HIV status among drug users. Some small studies at treatment centres have suggested that up to 54% of researched cohorts of users are HIV positive (Keenan *et al.*, 1993; McKeown *et al.*, 1993). In a follow-up study of 45 pregnant opiate users (Keenan *et al.*, 1993: 253) it was found that 24 of the women (53.4%) were HIV antibody positive as compared with 15 (33.3%) in an earlier study carried out in 1986 (O'Connor *et al.*, 1988). In another study it was reported that 54% of the drug users profiled, a total of 58 individuals were HIV positive (McKeown *et al.*, 1993: 53). However, the authors continued in pointing out that this was much higher than the national prevalence among drug users suggested by the Department of Health statistics at that time, indicating that 11.8% of drug users who had been

tested were HIV positive (Department of Health, 1993). Research carried out in 1991 reported that of 81 injecting drug users attending a Dublin needle exchange who participated in their study of HIV prevalence and associated risk behaviours, 14.8% were HIV positive (Johnson *et al.*, 1994). Another study of 186 women drug users attending an inner-city drug project found that 86 women (42.2%) attending were known to be HIV positive (Woods, 1994). In a larger study, Fitzgerald *et al.* (2001) found that 16.7% of the treated drug user population was HIV positive.

Approximately 10% of injecting drug users receiving treatment are HIV positive (Long, 2006: 14). The HIV figures reported by the Health Protection Surveillance Centre in May 2007 reported that cumulatively to the end of December 2006 the number of individuals tested HIV positive in the Republic of Ireland totalled 4,419 individuals, of whom 1,327 (30%) were injecting drug users (HPSC, 2007). Although a gender breakdown of the cumulative number of HIV positive drug users is not available, earlier studies indicated that a quarter to a third of HIV affected drug users are women (Farrell, 2001; Foreman & Mulcahy, 1997; NDSC, 2004).

Hepatitis C (HCV) prevalence among injecting drug users varied between 52% and 76% in a range of studies (Allwright *et al.,* 1999; Long *et al.*, 2001; Smyth *et al.,* 1998; Smyth *et al.*, 1999). A number of studies have noted slightly higher infection rates in women (Long *et al.*, 2001; Smyth *et al.*, 1994; Smyth *et al.*, 1995; Smyth *et al.*, 1998), one study of prisoners in fact concluding that prevalence in women prisoners was significantly higher and that female gender was an independent risk factor for not only Hepatitis C but also for Hepatitis B and HIV (Long *et al.*, 2001: 1). Again recently it has been suggested that around 70% of injecting drug users attending treatment services have tested positive for antibodies to the Hepatitis C virus (Long, 2006: 14)

Women and children first?

While there is no doubt that the majority of Irish drug users and those in treatment are young, unemployed men, who left school before the official school leaving age and live with their families of origin, a third of all drug users in treatment are women. The NDTRS reports from drug agencies or treatment statistics about drug use may eclipse certain realities, not just about the numbers of women involved, but about the issues they experience and about both men and women drug users' involvement in parenting. Risk factors are argued to be more pronounced for women, possibly because of social, economic resource and gender inequalities (Miller & Neaigus, 2002; Tompkins *et al.,* 2006; Zierler & Krieger, 1998). There is evidence that drug use among women prisoners is proportionately higher than among their male counterparts (Allwright *et al.*, 1999; Carmody & McEvoy, 1996; Department of Tourism, Sport and Recreation, 2001). Infection rates with Hepatitis C may be higher among women (Allwright *et al.*, 1999; Long *et al.*, 2001; Smyth *et al.*, 1994; Smyth *et al.,* 1998; Tompkins *et al.,* 2006). Women are proportionately more likely to be involved in risk behaviours with regard to sharing injecting equipment as suggested by these and the HRB/NDTRS studies. Although the numbers of drug-related deaths among men are considerably higher, a study of drug-related deaths in Ireland has noted that between 1994 and 2000 there was a steady

increase in deaths of women from one in 1994 to 29 in 2000, somewhat leveling off in the two following years (Long, Lynn & Keating, 2005). Being homeless may affect women disproportionately as a result of their drug use (Cox & Lawless, 1999; Woods, 2000). So while there are fewer women drug users overall within the treatment system and on the street proportionately, the difficulties they experience may be different, greater or more severe than those experienced by men in a similar situation. However, few policy documents have seen fit to identify the need for specific strategies to respond to women who use drugs or to their children, should a response be necessary.[10]

The *First Report of the Ministerial Task Force on Measures to reduce the Demand for Drugs* (1996:10) commented briefly:

> There are gender differences. A higher proportion of female addicts is living with a partner and that partner is likely to be an addict. This raises a tantalising question. Is female addiction to a significant degree driven by personal relationships? There is also a decline in the proportion of those presenting for treatment who are female and a corresponding increase in the proportion who are male. Again a question. Is there an internal dynamic pointing to a further reduction in drug addiction among females.

Nevertheless, no specific measures were proposed. However, whereas women's issues have not captured the imagination of service providers and policy makers in and of themselves, children's issues and drug users' involvement in parenting have appeared to do so.

Although services for drug users have developed in Dublin over the past thirty years, there has been little specific attention, at either policy or practice level, to the childcare problems which may arise in this context until recently. As services are currently structured, statutory child protection social workers, who are primarily responsible for decision-making in child care, often find it difficult to build up knowledge and expertise in relation to drug problems, while specialist drugs workers may lack familiarity with child welfare and protection issues. Regrettably there are no official data gathered with regard to the children of men and women who attend agencies for treatment in the Dublin area. The numbers of children born to or cared for by those who are in receipt of drug treatment are not currently officially collated or available.

However, it has been suggested that there are increasing numbers of children, particularly in Dublin, who are living in families where one or both parents use drugs and hence are being exposed to parental drug use (Hogan, 1997; McKeown *et al.*, 1993; Shanks, 2000; Woods, 1994; Woods & Daly, 1995). The first report of the findings from the Research Outcome Study in Ireland (ROSIE) reported on the treatment outcomes of 305 drug users (75% of the original recruited population) who were contactable a year after first entry into treatment. Of the 404 drug users

[10] A policy paper focusing on social care and treatment for drug users in Ireland (Cox & McVerry, 2006) recently published by the Drug Policy Action Group highlighted only two case studies in order to make its arguments and recommendations for a more integrated and comprehensive system of social care. However, both cases employed were young men, seemingly unattached and childless.

initially recruited, 56% of respondents were the parents of children under 18 years and over half of those who were parents did not have their children in their care (Cox *et al.*, 2006:2). Prior to this report's publication the data were publicly presented[11], suggesting that the 404 individuals (302 men and 102 women) reportedly were the parents of a total of 391 children. It was stated that, since this figure equals .96 children per person, applying this to the estimate of 14,452 opiate users in Ireland (Kelly *et al.*, 2003) suggests that at the very least there are 13,873 children of opiate users in Ireland.[12]

There has been increasing local interest in the needs of such children. A service, designed in 1993 for drug-using parents and their children to be jointly managed by the Ana Liffey Drug Project and the Eastern Health Board[13], was eventually established in 1999. A Children's Research Centre in Trinity College was established in 1995, one of its first projects a study of the social and psychological needs of the children of drug-using parents. In two Dublin community care areas, services specifically focused on meeting the needs of parents and children affected by drug use have been established. Several agencies have taken cognizance of children's issues as is evident from the many reports, grey literature and publications emerging (Bowden 1996, 1997a; Doran & Ni Chualain, n.d.; McKeown & Fitzgerald, 2006; McKeown *et al.,* 1993; Shanks, 2000; Weaver, 1998; Woods, 1994; Woods & Daly, 1995).

A study focusing on the provision of childcare facilities at drug treatment centres and programmes highlighted the paucity of services and facilities for women and children despite focus on this issue since the late 1980s (Moran, 1999). In the National Drugs Strategy document (2004) outlining the proposed measures to be fulfilled between 2001 and 2008, only one measure concerned with the provision of childcare is identified, stating that the then heath boards, now the Health Service Executive (HSE), need

> to consider as a matter of priority, how best to integrate childcare facilities with treatment and rehabilitation centres and how childcare can best be provided in a residential setting. (2004: Measure No 54)

Yet an addendum to this measure noted

> It is felt that the HBs should aim to provide drop in play areas/crèche rather than full time facilities as this may lead to further stigmatisation of children of drug misusers. Ideally, the HBs would like to be in a position to fund regular child care places for people attending their services and in some cases are in a position to do so for those on full time rehab courses. (2004: Measure No 54)

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[11] Presentation by Mairéad Lyons, Director, National Advisory Committee on Drugs (NACD) – Merchants' Quay Project and Barnardos, November 2005.

[12] This figure may of course be grossly overestimated. After all, much double counting may have occurred, for example, there may be many couples where children are double counted or indeed there may be many childless men and women. In the Ana Liffey Drug Project study (Woods, 1994) while 75% of the women were parents, 25% had no children.

[13] This proposed service, although argued for in the *Report of Adequacy: Child Care and Family Support Services in 1994 and 1995* (Eastern Health Board, 1995; Eastern Health Board, 1996), due to personnel changes in the Board did not come into being at that time. Resubmitted in 1997 following the acquisition of considerable non-statutory support by the voluntary agency concerned, in 1999 a social worker was employed and the service developed. It has since been evaluated (Downes & Murray, 2002).

Despite the concerns expressed by practitioners about the welfare of the children of drug-using parents, little additional resources in the way of childcare are to be offered to their mothers.

Interest in motherhood generally has proliferated in recent times in Ireland, as evidenced by a number of academic, research and popular publications (Enright, 2005; Kelly, 2005; Kennedy, 2002, 2004).[14] This resurgence in interest in motherhood and the acknowledgement of its neglect by feminists occurs at a moment in Irish society when the 'motherhood' clauses in the Constitution once again are receiving attention and there is constant discussion and debate but little action about childcare. The Irish Human Rights Commission has recently raised concerns about these clauses arguing that they are anti-woman and expressions of inequality.

Conclusion

This introductory chapter has presented a summarised account of how illicit drug use has emerged as a social problem over the past thirty years in Ireland, how public policy has shifted incrementally towards an acceptance that structural – rather than individual – factors are key influences on such drug use, and how harm reduction strategies have come to replace the abstinence model of care originally favoured by the Irish healthcare system. Against a backdrop of conservative cultural, Constitutional and legal forces, this chapter has also explored the particularly complex situation of women whose drug use is commonly perceived as having negative repercussions not only for themselves, but also for their children. While the chapter acknowledges that there have been some developments in terms of research, policy and practice on this issue, the aims of the present research are to look in detail at the experience of such drug-using mothers and their interactions with professionals from child welfare and drug treatment backgrounds.

In Chapter Two the literature focusing on women, illicit drug use and motherhood is reviewed while in Chapter Three the epistemological and methodological concerns of the study are explored and a description of how the research was conducted is presented.

The following five chapters present and discuss the findings of the study, exploring the women's experiences of motherhood and drug use. These chapters are organised around the stages of the mothering career or trajectory as identified by the women and workers interviewed. Chapter Four, Motherhood observed, rehearsed, anticipated and achieved, describes the women's transitions from childhood to womanhood, exploring childhood, educational and victimisation experiences. It then examines two major transitional moments, initiation into drug taking and problematic drug use and becoming a mother. Chapter Five, Motherhood performed, focuses on the women's

[14] Kelly (2005) studied the experiences of mothers who have relinquished their children for adoption in her recent Irish study impacted upon by her career in social work, naming their experience as one of motherhood silenced. Kennedy (2004) edited an academic tome focusing on the motherhood, mothering and being mothered experiences of a range of women writers, researchers and academics, while Enright's (2005) account of her own encounter with motherhood in *Making Babies: Stumbling into Motherhood* resonated with many Irish women's experiences.

experiences of performing parenting at various stages of their drug-using careers. Chapter Six, Motherhood watched, examines the surveillance and monitoring by professional workers in the drug treatment and social work services of drug-related motherhood and the women's mothering performance. In Chapter Seven, Motherhood interrupted, terminated or retrieved, the perceived everpresent threat of the loss of the motherhood role and the experiences of those who have lost child custody and their careers as mothers are discussed. It also looks at the second chance motherhood experiences of those who retrieved or recovered the role. Chapter Eight, Motherhood idealised, explores the women and worker participants' views of the contested meanings associated with drug-related motherhood and the women's aspirations to the idealised status of the 'Good Mother', highlighting the need for defending, justifying and maintaining the motherhood role.

Chapter Nine summarises and discusses the findings, examining the trajectory of drug-involved motherhood and the grounded theory – Preserving Motherhood - that has emerged from the accounts of the participating women's experiences. It examines implications for the harm reduction, drug treatment and social work projects arising from the empirical findings, reflects on the research experience and concludes with a focus on the discordant relationship between the harm reduction project on the one hand and on the other society's expectations of women and women's lived experiences as biological and social producers.

CHAPTER TWO

MOTHERHOOD AND DRUG USE REVIEWED: THE LITERATURE

> For women to take pleasure in either alcohol or illicit drugs themselves can still exclude them from their established roles of carer and moral judge. Such women are not proper women, are not nice women. In the nineteenth century, nice women campaigned against rum and took opium-laced tonics; their great-granddaughters have been able to find their femininity in campaigning against alcohol and opium alike, and in dutifully taking tranquillisers.
>
> (McDonald, 1994: 22)

In the context of this study, which aims to explore women drug users' experiences of motherhood in Dublin, this chapter reviews the literature focusing on women, illicit drug use and motherhood.

Throughout the last two centuries, in the United States of America (USA) and the United Kingdom (UK), periods of panic about women's drug use have occurred (Campbell, 2000; Kandall, 1996; Kohn, 2001; Perry, 1979, 1987). As Campbell (2000: 12) argued, they led to the emergence of

> ... a parade of fantastic figures – the "morphinist mothers" and "opium vampires" of the nineteenth and early twentieth centuries, the "enemies within" and the "girl drug addicts" of the 1950's, the heroin mothers of the 1970's, and the "crack moms" of more recent memory.

In the last two decades, women drug users' involvement with motherhood and children have been viewed and constructed as increasingly problematic and the phenomenon of the 'crack mom' and 'crack baby' focused concern and attention once again in the direction of women (Boyd, 1999; Gomez, 1997; Green, 1993; Humphries, 1999; Inciardi *et al.*, 1997; Mahan, 1996; Maher, 1990, 1992; Murphy & Rosenbaum, 1999; Paltrow *et al.,* 2000; Reinarman & Levine, 2004). Images of women as wayward, out of control, selfish, dangerous, diseased and unfit mothers underlay these intermittent panics. As the moral panic about crack mothers and babies fades from view, the new panic emerging in the USA relates to methamphetamine use, the children of such users described as living in 'meth homes' (Altshuler, 2005).

As reviewed in the introduction, in Ireland concerns about illicit drug use only intensified in the late 1970s and early 1980s, yet a medical study reported that maternal drug use was identified as a problem as early as 1981 (Ryan *et al.*, 1983). Some Irish research projects have focused specifically on issues pertaining to women drug users. Women's experiences of HIV (Butler & Woods, 1992), their use of needle exchanges (Geoghegan *et al.*, 1999), alcohol/ drug-involved pregnancy (Barry *et al.*, 2007; Keenan *et al.*, 1993; Kelly *et al.,* n.d.; O'Connor *et al.*, 1988; Ryan *et al.*, 1993; Scully *et al.*, 2004; Thornton *et al.*, 1990) and reproductive care (Shea, 1992) have been examined. Others have explored their experiences of service provision (Dunne, 1995; Nangle Connor, 2000), education (Bowden, 1997b, 2000; O'Neill, 1994; Weaver, 1998), prostitution

(Centre for Gender & Women's Studies (CG&WS), forthcoming; O'Neill & O'Connor, 1999) and their health (Lawless, 2002).

Significantly, a review of an educational project for women drug users in Dublin (Weaver, 1998: 23) concluded that 'where once demanding and self-centred women stood, there are now caring, compassionate people'. This conclusion revealed stereotypical representations of drug-using women as uncaring and unconcerned for others, confirming Perry's assertions (1979: 3) that

> Academic accounts are based on the same premises of "natural" gender differences, and female drug users are seen as deviating more from social norms for acceptable female behaviour than male illicit drug users do from male norms.

It appears reasonable then to suggest that the stereotypical images of women and mothers who use or have used drugs underlying society, media and academic accounts also underlie many of the accounts, approaches and interventions of drug treatment and social work services. Indeed, concerns with appropriate feminine characteristics and the deviating from these through drug use inform practice, research and policy. Social work involvement, drug treatment and what have been described as feminist practices of 'healing' (Ettorre, 1992; Sargent, 1992) often result in attempts to intervene and return women to what are regarded as traditionally appropriate roles and characteristics. Women oriented services frequently provide women with opportunities for treatment or recovery without challenges to the social structuring of the women as carers (Thom, 1994). Much feminist research, in addition to traditional perspectives, is claimed to have inadvertently perpetuated victimologies of women drug users, thereby infantilising them (Denton, 2001; Ettorre, 1992; Henderson, 1993a, 1993b, 1993c, 1994, 1999; Klee, 1996; Maher, 1995a, 1997). Alternate notions of drug-using women as victimised or villainous are central to accounts of drug use and motherhood. Policy and research in relation to drug use, pregnancy and parenting proliferate, while there are few examinations of the specific needs of women as mothers.

Murphy (1992) asserted that there are few naturalistic studies which focus on women and drug use, fewer on pregnancy and even fewer again on mothering and parenting beyond that of small babies.[15] Murphy-Lawless (2002) documented the experiences of Dublin women in a community affected by heroin, drawing on the experiences of non-drug-using women. More recently Duggan (2007) reported on the experiences of 30 families of heroin users seeking support services in Dublin. Again her 37 respondents, 20 of whom were women, were the parents (mostly mothers), siblings or partners of drug users. Both studies omitted to include drug-using mothers as participants or respondents. In an attempt to redress this imbalance, and as this study aims to explore women drug users' experiences of motherhood in Dublin, this chapter reviews the literature focusing on women, illicit drug use and motherhood. Divided into four sections, the first reviews

[15] There is little focus on the woman or the women's needs or lived experience of the situation. However while the majority of the studies carried out from a feminist perspective in the USA and Canada, claimed to explore issues in relation to pregnancy and motherhood, in effect they only described the women's lived experience of pregnancy.

key ideas, often conflicting, in the literature with regard to women's illicit drug use, drawing particular attention to images of women drug users. The second, focusing on motherhood and illicit drug use, initially reviews the ideology of motherhood generally and then examines the literature in relation to pregnancy, motherhood and drug use. Drug users' parenting involvement, practice and capacity, the potential negative impacts of their drug use and its associated lifestyle on their children and the protective strategies they employ to protect their children from exposure to difficulties will be reviewed in the third section. Having acknowledged throughout the impact of images of women drug users, particularly as mothers, the fourth section reviews literature pertaining to the dilemmas experienced by social workers in the assessment of fitness to parent and parenting capacity. In examining the mostly negative assumptions underlying studies of women's drug use, motherhood and parenting, the review will in conclusion identify a gap – the lack of a focus on women drug users' lived experience of motherhood as viewed by women themselves and professional workers interacting with them.

Women and drug use

It has been argued that in the past researchers ignored illicit drug use among women because of the smaller numbers of women involved or because they were regarded, contrary to the evidence presented by feminist research[16], to have similar experiences to their male counterparts (Ettorre, 1992; Rosenbaum, 1981a; Taylor, 1993). Research in the main failed to consider how women's lives differ from men's and have ignored sex and gender roles and the structural positioning of women in society. According to many there is a 'male as norm bias' in the addiction field (Wilke, 1994) where the male experience has been used as the standard measure in terms of treatment and general experience (Blenheim Project, 1988; Blume, 1990, 1992; Broom & Stevens, 1991; el-Guebaly, 1995; Ettorre, 1992; Lex, 1991; McDonald, 1994; Neale, 2004; Oppenheimer, 1989, 1994; Rosenbaum, 1981a; Sargent 1992; Taylor, 1993; Thom, 1994).

Despite these assertions that women's drug use has received little attention from researchers, a literature search reveals that there are many texts concerning women's drug use. Indeed significant interest has been directed towards women's use of drugs and the impact of this use on their social roles, as bearers and rearers of children (Blume, 1992; Boyd, 2004; Campbell, 2000; Gomberg, 1986; Kandall, 1996; Kohn, 2001; McDonald, 1994; Mayes, 1996; Oppenheimer, 1994; Rosenbaum, 1981a; Wolfson & Murray, 1986). This interest is increasing currently in the drug,

[16] Roberts (1981), Oakley (1974, 1979a, 1979b, 1980), Fonow & Cook (1991), Stanley (1990) and Stanley and Wise (1993) among others emphasised women's qualitatively different experiences of life and the social world. Broom & Stevens (1991), Ettorre (1992), Rosenbaum (1981a), Sargent (1992) and Taylor (1993), to name but a few authors, argued that women drug users' experience of drug use, both licit and illicit, and the social fall out of such use is qualitatively different to that of their male counterparts. The gendered nature of women's experience is highlighted consistently in feminist accounts. While some authors may look at the need for the development of services for women in their roles as gendered subjects, several feminist authors intervened at the level of questioning this gendered experience (Raine, 2001; Thom, 1994). Accounts by feminists have focused on how caring for others in itself creates dependency (Ettorre, 1992), the centrality and importance in women's lives of being or being able to be moral judge (McDonald, 1994) and acting as 'God's police' in controlling unruly and wayward men (Broom & Stevens, 1991). Such literature identified how women then strategise to avoid stigma and labelling.

nursing, medical and social work fields, as it is suggested that the gender gap is closing with increasing numbers of women using drugs (Goode, 1999; Neale, 2002)[17] and increasing numbers of children are reportedly living in families where one or both parents are drug users (ACMD, 2003; Bancroft *et al.*, 2004; Barnard & McKeganey, 2004; Hogan, 1997, 1998; Hogan & Higgins, 2001a, 2001b; Klee, 1998; Scottish Executive, 2001).[18] Less attention is paid to the wider experience of women outside of the reproductive or pregnancy experience (Boyd, 1999; Klee, 1998; Murphy & Rosenbaum, 1999; Neale, 2004) exemplified, it is asserted, by a lack of interest in women drug users past childbearing years (Finkelstein *et al.,* 1997; Gomberg & Nirenberg, 1993).[19] This focus on reproduction and pregnancy has also been noted in the Irish situation (Farrell, 2001; Hogan, 1997; Mayock, 2003; Moran *et al.*, 1999; Woods, 2000a).

As a result much of the literature about women's drug use or alcohol use has taken for granted women's position and roles in society as 'natural' or 'normal' rather than socially constructed. As Gomberg (1982) suggested, the taboos against women's alcohol and drug use have been common in societies traditionally and arise as a result of concerns about women's virtue and their child bearing and rearing obligations (Gomberg, 1982; Kandell, 1996; McDonald, 1994). Women are seen to deviate not just in terms of their illicit drug use but also because they do not conform to the image of female or woman as is understood or as is prescribed by society. A woman who uses drugs, in effect, flouts the prescribed sex roles.

There is little doubt and substantial evidence to suggest that women's experience of drug use, initiation, drug treatment, the criminal justice system, the medical system is qualitatively and significantly different to that of their male counterparts. Both qualitative research of lived experience of women and quantitative studies of large data sets of women and of women and men have demonstrated differences between men and women in their drug use and associated activities and behaviours.

There is evidence both in the international and Irish literature, as discussed in Chapter One and confirmed by recent overviews (EMCDDA, 2006), that women use illicit drugs less frequently than men. Many studies suggested that women are commonly introduced to drug-taking by men, mostly partners, who are their main drug providers in their ensuing drug-using careers (Amaro & Handy-Fanta, 1995; Anglin *et al.*, 1987; Binion, 1982; Cuskey, 1982; Eldred & Washington, 1976; Ettorre,

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[17] This is somewhat contradicted by the findings of a study conducted by the EMCDDA published in 2006 which suggests that in fact the gender gap is not narrowing.

[18] According to the ACMD report *Hidden Harm* (2003) there are 250,000 – 350,000 children living in families in the UK where parental drug use is an issue.

[19] There is little interest in women's drug use past childbearing years. Almost all texts present as a rationale for the study of women drug users the fact that most are of childbearing age. It is interesting that the literature concerns itself with this time scale and looks less at the drinking and drug use of young women/girls or older women. Interesting gender issues are being identified in studies of alcohol use among women and variations in drinking and drug use during different periods of the life cycle (Waterson, 2000) and in studies of recreational illicit drug use (Coveney, 2005; Henderson, 1999; Hinchliff, 2001; Parker *et al.,* 1998). Some American commentators have argued compellingly for an understanding of a life cycle perspective (Finkelstein *et al.*, 1997; Gomberg & Nirenberg, 1993).

1992; Grella & Joshi, 1999; Hser, Anglin & Booth, 1987; Hser, Anglin, & McGlothlin, 1987; Klee, 1997; Maher, 1995, 1997; Reed, 1985; Robbins, 1989; Rosenbaum, 1981a; Sargent, 1992; Sterk, 1999a; Taylor, 1993; Waldorf, 1973). The belief that women's relationships to 'the three D's - doctors, dealers and darlings' – create the greatest risks of drug use and addiction for women as suggested by Johnson and Auerbach (1984) underlies many studies as noted by Ettorre (1992). Sargent (1992: 90) suggested that the 'he-gives-and-she-uses' pattern was most common in her study. However some naturalistic or ethnographic studies of women drug users have identified their purposeful participation in the world of drug use and have stressed that women may have a more self-determining role in commencing drug use and often provide for their males partners' drug needs (Friedman & Alicea, 1995, 2001; Henderson, 1999; Maher, 1992, 1995, 1997; Mayock, 2000; Morgan & Joe, 1996, 1997; Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993).[20] While several studies suggested that there are many barriers to women seeking treatment and that women come later to treatment if at all, other findings revealed that women seek treatment or professional help earlier in their drug-using careers (Grella & Joshi, 1999; Vogt, 1998).

Identifying this field as resistant to the notion of gender, Ettorre (1992) accused the addiction treatment and research arena of gender bias and the acceptance of 'erroneous assumptions' about women substance users. Many advocate a gender sensitive or feminist focus (Ettorre, 1989, 1992, 1994, 1997, 2004; Ettorre & Riska, 1995; Henderson, 1993a, 1993b; Maher, 1997; Rosenbaum, 1981a; Sargent, 1992; Taylor, 1993; Vogt, 1998) challenging the gender blind, 'peopling of women' or insensitive nature of much of the traditional work.[21]

A focus on gender and gender issues is 'often a euphemism for exploring the female point of view' (Sherr, 1996: 16). However, gender issues have been described as pertaining to both the male and female experiences. It has been suggested that gender is something created through interaction as the result of '... social doings of some sort' (West & Zimmerman, 1991: 16) rather than a role or trait. As Oakley (2002: 50) claimed, 'gender is not simply a property of individuals but a set of interactive processes whose influence needs to be accounted for in any research process'. Gender then relates not just to biological and sexual differences but to the socio-cultural expectations and interactions associated with them (Room, 1996). The categories 'man' and 'woman' find their meaning within the system in which they exist. Sex differences do not exist in isolation to or external to the cultural perceptions of them and these perceptions are gendered (McDonald, 1994). In the resulting gender system, men are socially located primarily by their relationships to the means of production and women by their reproductive work socially and sexually (Campbell, 2000; Sargent, 1992).

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[20] See Appendix I for an addendum to this literature review focusing on women's drug careers, their partners, psychosocial issues and treatment involvement.

[21] However, there is by no means consensus among feminists writing in the addiction field as highlighted by contradictory accounts and commentaries (Ettorre, 1992; Henderson, 1993a, 1993b; Hinchliff, 2001; Sargent, 1992).

Drug use among women, it appears, then arouses different and greater concerns than drug use among men, because women's drug use inevitably means that they deviate not just as drug users but as women from the acceptable behaviours for those involved or potentially involved in childbearing and child rearing. The deviance or abnormality of women's drug use provides the main impetus for studying women drug users (Maher, 1997; Perry, 1979; Rosenbaum, 1981a; Taylor, 1993). They are then regarded as more 'defective', 'harder to treat', 'sicker', less motivated and more 'deviant' than men (Finkelstein *et al.*, 1997). These images and assumptions then impact on research about women, their health and psychosocial issues and their experiences of treatment, never mind their experiences of pregnancy and motherhood.

Images of women and women's drug use

While several explanations for women's use of drugs have been offered, accounts of women's drug use and the reasons for this use have generally drawn on what Friedman and Alicea (2001: 69) described as 'escapist, retreatist and psychoanalytical perspectives' (Ettorre, 1992; Maher, 1997; Perry, 1979; Rosenbaum, 1981a; Sargent, 1992; Taylor, 1993). Social explanations or understandings of social impacts have been rare in traditional research endeavours with women. As Perry (1979: 4) suggested, women's illicit drug use has been 'desocialised' and viewed

> as a pathological personal reaction to "normal" social life which incapacitates a woman by making her dependent unproductively and unprofitably – she is unable to function through factors beyond her control and for which she is not responsible – faulty upbringing, wrong type of male influence.

Drug users have generally been the victims of misrepresentation and stereotyping (Neale, 2002). Furthermore, Taylor (1993: 3) offered a compelling catalogue of specific portrayals of women drug users in previous research and academic accounts. Women drug users, she suggested, have been regarded as having less will power, morally weaker, sicker, more deviant, more emotionally and psychologically disordered, excessively dependent, conservative, hold traditional values, experience low self-esteem, are sexually deviant and are bad, unfit mothers. Women drug users have also been viewed as 'polluted' (Ettorre, 1992: 77; Wolfson & Murray, 1986), and their drug use as 'femininity defiled' (Perry, 1979: 3). They are also regarded as selfish and uncaring and as unfit and inappropriate to parent or mother their children (Campion, 1995; Klee, 1998, 2002c; Neale, 2002; Perry, 1987).

Despite the existence of multifaceted and ecological frameworks such as that of Zinberg's drug, set and setting (1984), women's drug use generally is defined in terms of personal deficits and pathologies and the social context and setting in which it takes place is often ignored. Women are perceived as medicating themselves because of their psychological and psychiatric difficulties, depression, and experiences of sexual abuse as children. While self-medication is of course one explanation for some women's illicit drug use, there seems often to be a comfortable acceptance of this notion rather than envisioning women's use as resistance or the pursuit of pleasure (Ettorre, 1992; Friedman & Alicea, 2001; Henderson, 1993a, 1993b, 1993c, 1994, 1999; Hinchliff, 2001; Maher, 1997). Some advocate an analytical and theoretical perspective that takes account of both

processual and social structural issues (Ettorre, 1992; Perry, 1979; Raine, 2001; Sargent, 1992).

Women's drug use, licit or illicit, is rarely conceptualised as a strategy to cope with managing the effects of poverty, deprivation, living in unsuitable or unstable accommodation, dealing with sexism, racism, or classism. Several studies, particularly those focusing on the recent 'crack mom' phenomenon in the USA, revealed that increased prejudice and intensified images of certain groups of women as being at risk have been constructed. Belonging to a particular social group, such as lone mothers, minority group, class, locale or being a public patient, can be enough to define a woman as at risk for drug use and lead to being tested or screened.[22] This suggests the need for an analysis that takes account of social context, environment and the setting in which drug use takes place and in which women drug users live their lives.

On the other hand, the view that women use drugs, particularly prescribed drugs, to assist them conform to or maintain their social role, particularly as mothers, is frequently proffered (Cooperstock & Lennard, 1986; Cooperstock & Parnell, 1982; Ettorre, 1992; Ettorre & Riska, 1995). Prescribed drugs, such as tranquillisers and anti-depressants, are those often offered by doctors and marketed by pharmaceutical companies to women, who reportedly outnumber men by two to one as users of these drugs (Farmer, 2003; McDonald, 1994; Rosenbaum, 1981a). Prescribing of such drugs to women is seen 'as "good" or socially necessary to maintain domestic bliss or the stability of the family' (Ettorre, 1992: 8, 1985). Therefore, prescribed drugs may be seen as 'mothers' little helpers' or 'mothers' pick-me-ups' (Hart, 2004: 10) or indeed working 'mothers' little helpers' where women are involved in both waged work outside of the home and unpaid labour within it.[23] In addition, the use of licit drugs, such as alcohol and tobacco, while not exactly acceptable for women is not 'beyond the moral pale' as illicit use has been described. Illicit drugs, such as heroin or cocaine, are not regarded as 'mothers little helpers', although more recently methadone, a synthetic opiate prescribed to women heroin users, has been described as the 'mothers' drug' (Hollis, 1998). These drugs are certainly not used by 'nice' women or 'proper' women (Campbell, 2000; Cooperstock & Lennard, 1986; Cooperstock & Parnell, 1982; Ettorre, 1992; Hart, 2004; McDonald, 1994). Ettorre highlighted how the tranquilliser or anti-depressive user 'as both "strung-out patient" or "dutiful wife"... may remain less visible than her heroin-using counterpart: the female junkie' (1992: 67). Despite this, it is notable that few feminists, either researchers or campaigners, have engaged with the issue of illicit drug use among women (Ettorre, 1992; Henderson, 1993a; Sargent, 1992; Woods, 1992). Although Sargent (1992: 118) has

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[22] The legal, medical, nursing, social welfare and social work systems' prescription of mothering and child rearing practices among women, particularly 'women of colour', poor women and substance-using women in North America (USA and Canada) has been documented by a large number of authors (Boyd, 1999; Campbell, 2000; Chavkin, 1990, 1992; Gomez, 1997; Green, 1993; Humphries, 1999; Humphries *et al.*, 1995; Maher, 1990, 1992; Paltrow *et al.*, 2000).

[23] As Ettorre (1992: 64) pointed out, 'during a periods of economic recession, society needs to keep its growing number of non-workers (women) in their traditional roles of housewives, mothers, caretakers and nurturers'. However, in times of prosperity or in a tiger economy such as the current Irish experience, it is necessary to define women as both mothers and workers as also noted by Ettorre (1992: 57), as society needs to keep women in the double or 'second shifting' role (Hochschild, 1990) in the workforce in the public sphere and in their traditional roles simultaneously.

suggested that 'women drug users and feminists have something in common!' in that their drug use or feminism may be seen as individualistic, unfeminine and 'as a seeking for power' (1992: 240), it appears that feminists and women drug users are presented as mutually exclusive groups and that feminists, researchers and policy writers, with few exceptions, have indeed distanced themselves from their heroin-using sisters.

Images of women as victims or villains are relevant to how women are perceived in varying contexts as less or more deviant precisely because they are women and are violating norms about drug use and femininity simultaneously by the use of illicit non-prescribed drugs (Broom, 1994; Broom & Stevens, 1991; Campbell, 2000; Maher, 1997; Philip *et al.*, 1997; Taylor, 1993). Attempts to rescue women, therefore, are often undertaken. Klee (1996: 167) suggested that 'in an effort to "rescue" female drug users from "blame" for their own circumstances' there is a danger of colluding in women drug users' disempowerment where there is an implicit assumption that they have no control over their lives. Where some suggest that women are 'doubly addicted' and dependent on drugs and men, their drug use may even be viewed as a strategy to resist this choice and several authors have usefully problematised the construction of women as helpless victims with little control over their drug use and their lives generally (Friedman & Alicea, 2001; Henderson, 1993a, 1993b, 1993c, 1994, 1999; Maher, 1995, 1997). Victomology and negativity are characteristic of much of the writing, even that which is feminist in approach (Henderson, 1993c).

Whether women's reported increasing use of substances is evidence of increasing social equality and liberation is debatable. Rosenbaum (1981a: 7) posed several questions about this issue in her ethnography of women drug users.

> Is the female addict a liberated woman who breaks through sexual barriers and functions alongside men in the heroin world? Or is she doubly oppressed and exploited as an addict and a woman?

Chein *et al.* (1964) suggested that women drug users denied their passive nature by using drugs. These issues remain contentious today within the victim/volition and structure and agency debate. In her introduction to an edited collection of chapters devoted to examining gender and substance use, McDonald (1994: 23) suggested that they

> challenge simplistic notions of "stress" or "alienation" as the cause of alcohol or drug consumption ... neither women's drinking nor their abstinence from drink can be simplistically equated with female oppression.

Commentators and researchers, among them feminists, are divided on this convergence or emancipation thesis debate that has emerged in studies of women's drug use and involvement in criminal activity. As seen already, Sargent (1992) suggested also that women's drug use might be evidence of strength and resistance. However others suggested that in fact it might be evidence of continuing oppression (Ettorre, 1992; Sandmaier, 1980).

These varying images and starting points for viewing women drug users have variously influenced work on women's experience of street drug use, their pathways into drug use, their involvement in criminal activity and drug dealing, their experiences of treatment and their roles as child bearers and mothers. Women's illicit drug use is condemned because women in this situation fail to care for and control men through their performance as 'God's Police' (Broom & Stevens, 1991: 26), or 'abandon(s) (their) moral stewardship' (Ettorre, 1992: 75). The 'fallen woman' or 'fallen angel' image pervades the literature, as does the image of the unfit mother. Not only must women adopt sobriety but also they must return or be returned to their socially approved roles of caring for men and children.

It has been remarked upon that women then minimise their involvement in deviant, drug-taking, dealing and other criminal activities as a means to influence others' perceptions of them as women, mothers, partners or wives and to avoid being labelled as 'criminals', 'drug addicts' and 'alcoholics' (Heidensohn, 1996; Horwitz & White, 1987; Maher, 1997; Thom, 1986, 1987). They also often minimise the harmfulness of their drinking or drug use. Stigma and the management of a spoiled identity are argued to be greater challenges for women, particularly for mothers (Klee, 2002a).

Women are almost always represented as mothers, family members or as responsible for family issues (Dumas, 1992; Rosenbaum, 1981a; Taylor, 1993). The 'unfit mother' notion arises again and again throughout the literature and will be discussed later in this chapter.

In summary, then the representations and images of women drug users as especially vulnerable to the adverse effects of drug and alcohol use, as doubly deviant or more recently, as simply keeping up with their male counterparts in a more egalitarian society are pervasive in society and are also evident in the addiction research field underlying studies. Sometimes analyses tend to oscillate between all three images. These images result in different points of departure for analyses of women's involvement with illicit drugs and motherhood. This section pertaining to women and drug use has focused on several pertinent key themes across the literature. The next section will examine some of the literature focusing specifically on mothering and drug use.

Illicit drugs and motherhood

Concerns about women's involvement in illicit drug use abound, largely relating to issues such as female virtue and women's role as mothers. One of the strongest images of women drug users is that they are unfit mothers (Friedman & Alicea, 2001; Perry, 1979, 1987; Smarsh Hogan *et al.*, 2006; Taylor, 1993), regarded as 'abusers twice over' – abusers of drugs and of their children (Norman-Bruce & Kearney, 1990), at worst as child abusers and at best as the neglecters of children (Colten, 1982). This section of the literature review will address three areas – the first motherhood, the second pregnancy and drug use and the third, motherhood and illicit drug use and will examine some of the challenges facing women who both use drugs and are mothers.

The ideology of motherhood

Researchers of many disciplines have reflected on motherhood and parenting internationally. However, there have been until the last two decades few studies of women's experiences of motherhood and those studies have tended to focus on biological conceptions of maternity thereby concealing 'the gendered politics of social and "natural" relations' (McMahon, 1995: 6). Sociological studies of motherhood as an institution and the study of motherhood as a role or career presented new departures for focusing on concepts of motherhood as 'invented' (Dally, 1982) or socially constructed. Motherhood as institution, a social construct, an ideology on the one hand and experience on the other (Rich, 1986) and the notion of being a mother and doing mothering (Enos, 2001; McMahon, 1995) have been studied.

Many have focused on the ideology of mothering, a powerful notion. As suggested by Boyd in her study of women drug users' experience of pregnancy and of interactions with medical and social services (1999: 8),

> Motherhood is central to the debates surrounding prenatal drug use and social service intervention ... mothers have been romanticized as the givers of life and the caretakers of society's children, self-sacrificing and powerful in their maternal love.

Since it is against this backdrop that women drug users imagine, enter into and perform motherhood, a brief discussion of this ideology merits a mention here. The 'myth of motherhood' into which women are socialised then presents motherhood as a specific, natural experience to which all women must aspire and be suited. Where difficulties arise and women experience ambivalence about motherhood, this is often perceived as women's failure and inability, their own personal inadequacy, to live up to this myth or ideology (Badinter, 1981; Kitzinger, 1978; Lewis, 2002; McMahon, 1995; Oakley, 1974, 1979a, 1979b, 1980; Phoenix & Woollett, 1991; Woollett & Phoenix, 1991). Within the Irish context, this ideology of motherhood permeates Irish society and is evident in the clauses of the Irish constitution, Bunreacht na hÉireann, strongly influenced by images of motherhood in Catholicism (Inglis, 1998; Kennedy, 2004; O'Connor, 1998).

The ideology of motherhood is according to many commentators a middle-class, white and mainstream construct favouring the definition of those dominant and powerful groups of women in society, exerting its control over all women but particularly impacting upon the lives of those often constructed as 'other' in society (Baker & Carson, 1999; Boyd, 1999; Brown, 2006; Enos, 1999; Gillies, 2006; McMahon, 1995; Taylor, 1993). 'Other' women include lesbian women, women from minority ethnic groups, working-class and poor women and women who use illicit drugs. Such women are often categorised as 'problematic mothers' (Goode, 1999) and consequently the actual fallout or consequences affecting those who do not conform to this dominant ideology are themselves rarely problematised. Their experiences are constructed differently to those who are 'proper mothers'.

Most significantly this ideology of motherhood has made the unpaid work of mothering invisible

(Boyd, 1999). Indeed mothering is rarely described as work. Rather motherhood and parenting are conceptualised and presented as a vocational activities rather than as work, as reproductive labour, or as some have called it 'labours of love' (Rich, 1979) or 'love labour' (Ettorre, 1992; Finch & Groves, 1983; Lynch & McLaughlin, 1995). The 'naturalness' associated with motherhood then eclipses the fact that motherhood is socially constructed and that definitions of motherhood are affected by and may change as a result of the socio-economic, political, historical and cultural contexts in which they exist (Boyd, 1999; Enos, 2001; McMahon, 1995; Phoenix & Woollett, 1991).

McMahon (1995) described how women experience transitions to motherhood as a transformative process. Focusing on their paths to motherhood, she distinguished the experiences of the middle-class and working-class women in her Canadian study, identifying experiences of transformation and reformation respectively. She also identified the differences in women's definitions of good mothering and descriptions of their mothering activity and work, highlighting how middle-class women focus on affective issues while working-class women focus more frequently on the instrumental issues such as feeding, clothing and sheltering their children. She pointed out, as other authors have, that working-class women as mothers are more often monitored than middle class women (Baker & Carson, 1999; Boyd, 1999; Enos, 2001; Gillies, 2006; McMahon, 1995).[24]

Ideologies of motherhood and the family, therefore, are often foremost when looking at issues of good and bad, acceptable and unacceptable in terms of mothering (Boyd, 1999; Gillies, 2006). What constitutes nice, proper and good families is socially determined and defined rather than natural and self-evident. Differences then among women as mothers are important to mention. These differences are usually social, economic, class and ethnicity based.

Pregnancy and drug use

Pregnancy, birth and becoming a mother have been presented as crucial moments for younger women, representing the achievement of adulthood and the establishment of feminine identity, and for women generally, whether drug-using or non-drug-using women (Butler & Woods, 1992; Chodorow, 1978; Griffin, 1985; Hannan & O'Brian, 1993; McCashin, 1996; McMahon, 1995; Murphy, 1992; Oakley, 1980; O'Connor, 1998; Murphy & Rosenbaum, 1999; Sterk, 1999a). Indeed it has been suggested that early parenthood may present a young woman with an opportunity to move into independent living and leave behind problematic family circumstances (Phoenix, 1990). However pregnant women's use of drugs evokes concerns about the foetuses, the babies, the role of motherhood, society itself.

[24] Women from visible minorities, for example, African American women in the USA (Gomez, 1997; Green, 1993; Humphries, 1999; Kandell, 1996; Maher, 1997) and First Nation women in Canada (Boyd, 1999), are often more closely monitored, particularly because of their status as public rather than private patients within the maternity hospital setting. They are also more likely to be subjected to drug testing and screening than private patients.

As several researchers have noted, pregnancy and drug use merit significant attention across the health sciences and psychological literature (Boyd, 1999; Colten, 1982; Corser & Payne Adler, 1993; Kearney, 1993; Murphy, 1992; Murphy & Rosenbaum, 1999). Over the last twenty five years, a range of texts demonstrated extensive interest in women drug users' pregnancies, focusing on the medical, nursing and psychological issues concerning antenatal health, pregnancy outcomes, prenatal drug exposure, neonatal abstinence syndrome (NAS) and the health of neonates (Barry *et al.,* 2007; Black *et al.*, 1993; Chasnoff, 1988; Chasnoff *et al.*, 1985; Dixon, 1987; Finnegan, 1985; Finnegan & Fehr, 1989; Finnegan *et al.*, 1975; Fischer, 2000; Fitzsimmons *et al.*, 1986; Hepburn, 1993a, 1993b, 1996, 1999; Kandall *et al.*, 1999; LaGasse *et al.,* 1999; McCarthy *et al.*, 1999; Scully *et al.*, 2004; Siney, 1995, 1999). The potential impacts range from foetal exposure to drugs *in utero,* prematurity, low birth weights to withdrawals or NAS and higher risk of mortality. Focus then is often on identification, monitoring, control, testing, treating and confining women during and after pregnancy in order to avert such harms and outcomes. Services, such as drug liaison midwifery, needed for pregnant women, have also been examined. The concerns about women's drug use during pregnancy are many and maternal drug use is generally perceived as a risk for poor maternal outcomes.

However, while many studies justifiably identified the difficulties experienced by foetuses/babies *in utero* and in the immediate post birth environment as a result of prenatal drug exposure, the unequivocal results of these studies and their universal application to the experience of all women drug users and their children have been questioned (Boyd, 1999; Campion, 1995; Hepburn, 1993a, 1993b, 1996, 1999; Mayes *et al.*, 1992; Murphy & Rosenbaum, 1999; Reinarman & Levine, 2004; Rosenbaum & Irwin, 2000). Methodological issues have been raised about some studies, several of which have been most influential with regard to prenatal drug exposure. Indeed, some early studies of the impact of maternal drug use which suggested extensive impacts and damage to children have later been challenged and contradicted. In several cases the researchers themselves have reviewed their early findings (Chasnoff *et al.*, 1985) and stated implications in the light of their later studies and reviews (Chasnoff, 1993).[25] As Campion (1995: 172) suggested in her review of drug-using parents

> ...all babies do not suffer the negative outcomes that the majority of published research suggests. Here again we need to question the nature of the research and the researchers and the bias of those who publish research findings.

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[25] Reinarman & Levine (2004) pointed out how the construction of the 'crack baby' and the unquestioning acceptance of the irreversible and universal effects of crack usage by pregnant women on their foetuses/babies emerged initially out of one small study of 28 pregnant women who had used cocaine published in the *New England Journal of Medicine* (Chasnoff *et al.*, 1985). The authors did offer a caveat, noting that it was a small study. The ensuing panic about crack babies was promulgated on the basis of few early clinical studies largely dependent on anecdote. Chasnoff (1993) later reviewed his initial claims. Reinarman & Levine (2004: 194) also drew attention to the findings of several authors that fears among crack-using women based on these media reports and claims lead many to decide to terminate their pregnancies (Koren & Graham, 1992; Murphy & Rosenbaum, 1999). It was also noted in a commentary on policing pregnancy that it was difficult for social services to find foster homes for babies, described as 'crack babies', removed from their drug-using mothers' care and custody. As a result many children were retained in hospitals as 'boarder babies' for lengthy periods because suitable homes were not available (Paone & Alperen, 1998: 104).

> Research which does not highlight adverse effects of drug use may be less likely to get an airing.

Boyd strongly asserted that 'in the light of the research available, neonatal abstinence syndrome appears to be a cultural fabrication'(1999: 36).

The automatic assumption that any health or psychosocial difficulty emerging for drug-using mothers emerges as a result of the mothers' involvement in illicit drug use pervades the literature and has been challenged by some. This myopic focus on drug use, described as the 'all down to the drugs' belief by Scottish obstetrician Mary Hepburn may have serious repercussions for women's and children's health and for the services responding. Hepburn (1996: 13-14) outlined the concerns many practitioners hold about women drug users' pregnancies and also attempted to debunk some of these myths. Popular ideas, she argued, suggest that during pregnancy 'detox is too dangerous'; that babies of drug users should be automatically admitted to special care nurseries even in the absence of specific medical problems; that drug use in pregnancy and withdrawals post birth cause 'permanent damage'; and that 'breast feeding is out'. She maintained that while sometimes there are difficulties and 'things can go wrong' that these do not occur in the vast majority of cases. Therefore it is necessary to allow women to make informed choices and decisions about their medical and social management without imposing dubious and 'scientifically unsound regimes'.

Rosenbaum and Irwin (2000: 93), also advocates of harm reduction/reduction of drug- related harm measures, found that the women heroin users in their study population approached their pregnancies with less anxiety than did women crack cocaine users.[26] This, they argued, was due to the effects of media coverage and 'moral panic' about crack cocaine, particularly its use during pregnancy in the late 1980s and 1990s in the USA. Strong arguments for the incorporation of harm reduction approaches during pregnancy have been made in the belief that this pragmatic approach, rather than a punitive one, is crucial for women's participation in ante-natal care and for impact on pregnancy outcomes (Kearney, 1993; Murphy & Rosenbaum, 1999; Rosenbaum & Irwin, 2000). Research has demonstrated that when women receive supportive and non-judgemental antenatal care maternal outcomes improve despite the range of socio-economic and other difficulties experienced by the women (Hepburn, 1993a, 1993b; Jackson & Klee, 2002; Klee, 2002b; Klee & Jackson, 1998; Klee *et al.*, 1996; Lewis *et al.*, 1995; McCrory & Harbin, 2000; Scully *et al.*, 2004; Siney, 1995, 1998,1999).

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[26] Significantly Barry *et al.*'s (2007) recent study of both illicit and licit substance use among the general population of pregnant women at the Coombe hospital in Dublin demonstrated high levels of use of alcohol during pregnancy. While women appeared to understand the risks of either illicit drugs like heroin and licit substance use such as smoking, the message about alcohol use seemed to be missed. In a similar fashion to the women described by Rosenbaum and Irwin (2000) and Hepburn (1996), they found that women carried varied ideas of danger and risk, often inaccurate.

Concerns about women's ambivalence, concealing pregnancies, not coming forward for ante-natal care, the level of drug use during pregnancy and the concealing of such, concerns for the infants antenatally exposed to drugs and concerns about the post birth environment have all been identified. Several research studies and ethnographies have examined the lived experiences of drug-using women while pregnant and soon after the birth of children exploring the meaning of pregnancy, impending and actual motherhood for women (Bolla, 1996; Boyd, 1999; Goode, 1994; Klee & Jackson, 1998; Klee, Lewis & Jackson, 1996; Maher, 1990; Murphy & Rosenbaum, 1999). However, except in a small number of studies which specifically argued for the importance of harm reduction measures (Boyd, 1999; Hepburn, 1996; Klee *et al.,* 2002; Murphy & Rosenbaum, 1999; Rosenbaum & Irwin, 2000; Taylor, 1993; Vogt, 1998), the impact of monitoring and intervention of services on women's ambivalence about motherhood or their reluctance to come forward for treatment has not engaged researchers and practitioners. There appears to be an assumption that women drug users are ambivalent about pregnancy and motherhood and that their pregnancies are unwelcome (Schilling *et al.*, 2004; Suchman & Luthar, 2000).

However, several qualitative studies have identified pregnancy and motherhood as significant and transformative moments in terms of change among women drug users (Baker & Carson, 1999; Boyd, 1999; Copeland, 1998; Flavin, 2002; Kearney *et al.*, 1994; Klee *et al.,* 1998; Mahan, 1996; Mayock, 2003; Murphy, 1992; Murphy & Rosenbaum, 1999; Pursley–Crotteau, 2001; Pursley-Crotteau & Stern, 1996; Rosenbaum, 1981a; Rosenbaum & Irwin, 2000; Sterk, 1999a; Taylor, 1993). In almost all the studies the impetus to stop drug use, reduce use or implement harm reduction strategies has been observed among women.

Many viewed pregnancy as a period of time during which women might be motivated to change their drug-using behaviours in order to accommodate their new role as mothers. However, pregnancies appeared either to motivate or further stress the women with regards to their drug use (Bourgois & Dunlap, 1993; Boyd, 1999; Colten, 1982; Deren, 1986; Eldred *et al.*, 1974; Goode, 1994; Irwin, 1995; Klee, 2002b; Murphy & Rosenbaum, 1999; Pursley-Crotteau, 2001; Rosenbaum, 1979, 1981a; Siney, 1995; Taylor, 1993).

In her small study of six drug–using women, Goode (1994) demonstrated that increases in drug consumption could take place during pregnancy. The stresses and strains experienced by women during pregnancy and post birth, particularly their fears and guilt about the impact of methadone maintenance, continued drug use or drug use early in the pregnancy, may in fact exacerbate drug use. This highlights in some cases the lack of supports for drug-using mothers with new infants and also suggests that harm reduction policies need to be introduced and influence practice and interventions with pregnant, drug-using women (Chavkin, 1990, 1992; Chavkin & Breitbart, 1997; Chavkin & Kandall, 1990; Flavin, 2002; Hepburn, 1996; Murphy & Rosenbaum, 1999; Rosenbaum & Irwin, 2000). The lack of such policies may prevent women seeking care.

Others (Klee, 2002d; Klee & Jackson, 1998) observed that use of drugs often diminished during pregnancy and stabilisation occurred. However, they also found that some time after pregnancy women had regressed or relapsed to previous drug-using behaviours and that the '"window of opportunity" that held great promise in late pregnancy gradually closes over the ensuing months' (Klee & Jackson, 1998: 67).[27] The stresses and strains of caring for a baby, and indeed the added difficulties of babies who have experienced withdrawals, may also exacerbate the drug use. Klee and Jackson also suggested that drug-using women's feelings of guilt about their drug use and its impact on their babies, particularly for those women whose babies do not experience withdrawals, diminishes over time. It appears that these findings point to the importance of proactive and supportive interventions, such as those described recently in the report of a pilot mother and baby project in Scotland (Addaction Scotland, 2006).

Concealing drug use and minimising involvement have been mentioned at several moments in this review. Women, it appears, are often reluctant to reveal their drug use during pregnancy. Largely this appears to be related to stigma and to fears of services' interventions. While many women may stop using drugs on discovering their pregnancies, others may access treatment and stabilisation. Some may find it difficult to stabilise on methadone or to remain drug free and consequently may vacillate between using street drugs and being drug free. Significantly, in Rosenbaum's 1981 study only 2-3% of the 70 women who were mothers acknowledged that they used drugs during pregnancy. Maher's (1997) women participants reported much higher levels of drug use during pregnancy. Twenty-seven women had given birth to a total of 57 children (59% of all the children) while they were active drug users.

While women may conceal their pregnancies, conceal their drug use and stay out of reach of services, the moment where women may be finally exposed is when they give birth. Murphy and Rosenbaum (1999: 102) described birth as the 'denoument' or 'the final showdown' while Kearney (1993: 117) named this moment as one of 'facing the music'. Birth experiences can be either positive or negative, the attitudes and practice of staff determining whether women experience the births of their children as positive or negative. Since birth is sometimes viewed as a transformative and redeeming experience, it appears that these windows of opportunity need to be grasped by all involved, thus the tone of studies advocating a more sympathetic and socialised analysis of women's experiences. The notion of the 'final showdown' relates to the experiences of women in the USA where often the women's involvement in parenting is prevented by the immediate intervention of Child Protective Services. Children's removal from their mothers immediately post birth have been described in a vast number of studies, particularly those carried out in the USA and Canada where certain policies prevail. A slower, considered and less punitive approach appears to inform the European experience.

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[27] It is also suggested that feelings of guilt diminish with time especially for women with healthy babies. However, the project did find at its close that women had moderated their use and those on methadone treatment had gained from their involvement with the services.

Nowhere is the treatment/punishment distinction more evident than in the debate that has taken place in the USA with regard to foetal rights and exposure to drug use. The policy implications and potential for increasing harm as a result of 'policing pregnancy' and criminalising such use has been discussed by a range of writers and commentators, from sociological, medical, nursing and legal perspectives (Bowers Andrews & Patterson, 1995; Campbell, 1998, 2000; Chavkin, 1990, 1992; Chavkin & Breitbart, 1997; Chavkin & Kandall, 1990; Glasser & Siegel, 1997; Gomez, 1997; Green, 1993; Hepburn, 1996; Humphries, 1999; Humphries *et al.*, 1995; Kandall, 1996; Kearney *et al.*, 1994, 1995; King, 1993; Maher, 1990, 1992, 1994; Mariner *et al.*, 1990; Paltrow *et al.*, 2000; Paone & Alperen, 1998; Reinarman & Levine, 2004; Rosenbaum & Irwin, 2000; Siegel, 1992, 1997; Siney, 1998; Young, 1994). Several research studies, as mentioned earlier, have been used to inform and fuel the social construction of the 'addict mother', the 'crack mom' and the 'crack baby' and the ensuing moral panic which raged in the US media. This debate has emerged out of the experiences of many women, mostly described as 'women of colour', who were identified as child abusers or maltreaters and lost custody of their children due to having used illegal substances during pregnancy, on the evidence of one positive drug test in many cases (Paone & Alperen, 1998: 103; Reinarman & Levine, 2004). Consequently, there has been momentum with regard to the criminalisation of drug use during pregnancy. Several have documented the experiences of women who were arrested, charged, found guilty of child maltreatment or attempted murder on the basis of positive drug tests during pregnancy, birth or shortly post birth (Flavin, 2002; Gomez, 1997; Humphries, 1999; Kandall, 1996). Flavin (2002: 975) referred to the 'all-or-nothing nature of discourse on drug use', pointing out that in the last two decades criminal justice interventions in the lives of women have been numerous. Over 200 women in the USA have been charged for their drug use during pregnancy (ibid: 973). Interestingly, these dichotomised responses were examined recently in the Irish context in an article examining the legal implications of drug use during pregnancy (Schweppe, 2006), suggesting that these issues may soon come to the fore in Ireland.

Experiences of drug-involved pregnancy and birth and their significance in society are followed by experiences of drug-involved parenting or motherhood, the focus of the next section.

Motherhood and drug use

In the Irish context, there was early identification of interest in women drug users because of pregnancy and their role as mothers. The importance of parenting in women drug users' lives has been documented and their involvement in caring for their children and partners highlighted (Butler & Woods, 1992). Some have described drug-using mothers as 'problematic mothers', 'reluctant non-conformers' (Goode, 1999), while others have suggested that the case of drug-using women further reinforce ideologies about women as 'problematic reproducers' (Shea, 1992). While the needs of children of drug users have been attracting significant interest (Hogan, 1998; Leopold & Steffan, 1997; Mayes, 1996), it appears that the drug user as parent is also attracting increasing attention (Barnard, 1999; Hogan, 1997, 1998; Hogan & Higgins, 2001a; Klee, 1998; Klee *et al.*, 2002; Lief, 1985; Powis *et al.*, 2000; Stewart *et al.*, 2007).

As mentioned earlier, women's drug use often elicits concern because of their involvement in parenting and child care. These concerns have often predominated in the literature. Lawson and Wilson discussed 'passively addicted infants enduring the life-threatening illness of withdrawal soon after birth ...' and argued that

> Drug addiction in women brings a special dimension to the dangers of chemical abuse: a threat to the well-being of small children, those unwilling participants who may suffer its full effects physiologically at birth and/or psychosocially throughout their development. (1980: 67)

During the same era, however, some researchers were highlighting the negative outcome of viewing the woman as secondary to her at risk offspring. Colten, in the course of her study, argued that despite the fact that the majority of drug-using women are mothers 'scant attention' has been paid by researchers or treatment providers to the meaning of the role in their lives. She asserted that

> [E]ntire conferences and monographs on the addicted mother and her family have appeared with barely a mention of the mother. She is viewed as an independent variable - as the source and never the victim of the problem – and seen only in the most negative terms...We know almost nothing about the fabric of the lives and the relationship between addicted mothers and their children beyond the infant or toddler stages. (1982: 78).

However almost twenty years later researchers were still highlighting this lack of attention to women drug users. Sterk (1999a: 100) echoed these sentiments in pointing out that little research has been carried out on reproductive issues and the meaning of motherhood to women drug users.

> The perspectives of the women themselves – their attitudes, values, norms, interpretations, and decision-making processes – are seldom considered.

In addition, Boyd (1999: 3) stated,

> Maternal drug use; assessment of risk; and the identification, regulation, treatments, and control of wayward mothers and their infants have become central concerns in 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 and on their infants is ignored.

So how do women drug users experience motherhood? The major challenges they encounter in the course of their lives as mothers and in coping with family life have been documented in several studies (Baker & Carson, 1999; Boyd, 1999; Colten, 1982; Friedman & Alicea, 2001; Goode, 1999; Kearney *et al.,* 1994; Maher, 1990, 1992; Morgan & Joe, 1997; Murphy, 1992; Rosenbaum, 1979, 1981a; Sargent, 1992; Sterk, 1999a; Taylor, 1993). Almost all the ethnographies of women drug users made reference to their experience of parenting, even if it was often only briefly in the contexts of their drug-using careers. The findings of Rosenbaum (1979, 1981a) and Taylor (1993, 1997) concluded that motherhood is the primary concern and responsibility of the vast majority of women drug users, is the key factor differentiating their experience from that of their male counterparts and that 'motherhood is their single claim to worthiness' (Rosenbaum, 1981a: 100). These writers also maintained that the risk of losing this important and central role presented the

greatest risk for women. Women drug users are reportedly concerned about children, want to be mothers, want to care for their children and gain much from being mothers (Hardesty & Black, 1999; Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993). Motherhood is seen as central in their lives. Hardesty and Black (1999) suggested that mothering itself is a survival strategy and a 'lifeline' for women drug users.

Like many women who work in paid employment in the formal economy and unpaid domestic labour and childcare, those with a history of drug use often have dual/multiple roles or careers (Klee, 2002d; Taylor, 1993). They have to 'take care of the business' of mothering and the business of drug-taking (Rosenbaum, 1979, 1981a; Woods, 2000) - a role as mother in the private sphere and in the public sphere, a drug career with its related activities or a drug treatment career. Drug-using women have much in common then with many women attempting 'to have it all' and in a similar way may indeed experience many of the same difficulties. These careers in both unpaid caring work and paid work mean that 'double shifting' or the 'second shift' (Hochschild, 1990) impacts on their lives and may cause considerable conflict.

However, women drug users' roles in the private sphere of motherhood, marriage, relationships and domesticity often conflict with their career in the public sphere of drug taking or criminal activity. Both careers are stressful and often affect the other. The stresses and strains of a career in drug use often lead women to believe that their lives will be greatly improved by motherhood and wifehood (Taylor, 1993). The stresses and strains of this career in the private sphere then sometimes exacerbates their need for drugs and drug-taking (Boyd, 1999; Goode, 1994; Morgan & Joe, 1997; Taylor, 1993), some women reporting that their drug use assists them in their role as mothers (Klee *et al.*, 2002; Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993). By virtue of their involvement in illicit activities - drug use, crime and 'deviant' behaviour - women drug users' role as mother is often brought into the public sphere where there is much concern and scrutiny. The collision of two identities and roles, that of drug user and mother, may cause major difficulties and challenges for women, their children, their families and those practitioners who engage with them.

Women drug users' struggles then by all accounts often revolve around these issues, but most pointedly it appears that the 'good mother' issue predominates, and as it has been suggested remains the concern of most women, drug-using or non-drug-using (Baker & Carson, 1999; Boyd, 1999; Brown, 2006; Colten, 1982; Coyer, 2003; Ettorre, 1992; Friedman & Alicea, 2001; Goode, 1999; Murphy, 1992; Rosenbaum, 1979, 1981a; Sterk, 1999a; Taylor, 1993, 1997). One Canadian commentator (White, 2001: 454) suggested that women drug users' outstanding performance as mothers is an act of resistance in itself. 'An illicit drug-using single mother taking excellent care of her children despite all the social messages about mothers who use drugs as "unfit" and "undeserving" of having children at all' represents an informal example of illicit drug users' political activism in the sense that it undermines the status quo and conventional wisdom about such women.

However, much of the literature suggests that women's concerns with good mothering are often compounded by demands placed upon them by the ideology of mothering. In her study of crack-using mothers, Murphy described how the 'ideological supervisor' (1992: 151-152) dictated the standards and practices that the women attempted to achieve. Their experiences of being mothered as children, the views and mothering standards of other mothers and those around them and the representations of mothers, mothering and motherhood are its key components. Kearney *et al.* (1994) also described how women try to make up for their drug use, to be good mothers and display a 'defensive compensation' in relation to their motherhood role and their children. Sterk (1999a: 131) also pointed out that many women believe that in order to be good mothers, they must be drug free.

The guilt that drug-using mothers feel about the possible, real or imagined impacts of their drug use on their children has been documented, as have their feelings of inadequacy as mothers and sense of failure as mothers (Boyd, 1999; Colten, 1982; Coyer, 2003; Goode, 1999; Hogan & Higgins, 2001; Irwin, 1995; Kearney *et al.*, 1994; Klee *et al.*, 2002; McIntosh & McKeganey, 2002; Murphy, 1992; Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993).

Several qualitative studies offered a picture of the concerns of drug-using mothers. Some demonstrated how women reconcile the two roles, as drug users and mothers, while others have provided accounts of how women manage childcare arrangements and reconcile separations from children as a result of incarceration or participation in residential treatment (Enos, 2001; Kissman & Torres, 2004; Knight & Wallace, 2003; McCann James, 2004; Schilling *et al.*, 2004). Several studies have identified the vulnerability of incarcerated women drug users and how women prisoners maintain their contact and connections with their children and families (Enos, 2001; Hanlon, O'Grady *et al.*, 2005; Lewis, 2004; Smith *et al.*, 2004). Much of the recent work on the woman prisoner has focused on her status as mother. Unsurprisingly, there are few studies of the male prisoner as father (CSET, 2002). Other accounts, which will be reviewed presently, have focused on the aftermath of separations from or loss of custody of children. Women's concerns appear, by all accounts, to be many, such as their involvement with their children, their living arrangements, their interactions with family members, interactions with drug treatment providers and social work services and coping with familial, service and societal disapproval.

In the face of media representations of drug-using mothers, discussed by some authors (Friedman & Alicea, 2001; Humphries, 1999), women experience the impact of public opinion about them as mothers. Many drug-using women themselves believe much of what the public believes to be true. As Friedman and Alicea (2001) pointed out, their women participants' gender socialisation as women meant that they did not reject all that they had learnt when growing up as girls about being good mothers, wives and daughters. Many felt that they had failed in their attempts to be good mothers, wives and dutiful daughters because of their involvement with drug use (2001: 110). In this finding, they echoed earlier ethnographers (Rosenbaum, 1981a; Taylor, 1993) who found that

their women participants sometimes espoused traditional views of femininity and motherhood.

However, stereotypical representations of drug-using mothers abound (Campion, 1995; Klee, 1996, 2002a, 2002c, 2002f). There are assumptions that the babies or children of drug-using mothers are at risk of neglect or abuse and that children should be removed from their care and either fostered or adopted. In her discussion of fitness to parent, Campion (1995: 170-175) highlighted how there are widespread negative beliefs about drug–using parents, almost invariably mothers. These include beliefs that they are incapable of putting their children's needs before their own, they cannot provide a safe and secure home and their children are at risk of neglect and endangerment. While Campion acknowledged that many of these assumptions are often difficult to refute and indeed many may apply to some mothers in this situation, drug use *per se* is not a justification for labelling a person as unfit to parent. Indeed several commentators have pointed out that in a number of research studies there seems to be an underlying assumption that drug use and parenting, or rather mothering, are mutually exclusive (Campion, 1995; Colten, 1982; Ettorre, 1992; Taylor, 1993). Campion (1995) questioned the nature of the research, the researchers and the bias of those who publish research findings about, for example, the dangers of drug use during pregnancy. Several commentators have demonstrated that research that does not stress the adverse effects of drug use may, in Campion's words (1995: 172), 'be less likely to get an airing' (Akin & Gregoire, 1997; Koren *et al.*, 1989).[28] Klee (2002a: 4) highlighted the abundance of stigmatising judgements about women drug users in the literature noting that 'an otherwise useful study on social workers' views of child neglect and abuse (Reid and Macchetto, 1999) frequently lapses into emotional if not incendiary language'.

Klee (1998: 439) also identified the characteristics attributed to the stereotypical drug user by health professionals in her studies – selfish and uncaring, irresponsible, distracted, neglectful, intolerant, irritable and aggressive, involved in no child-centred activity, and puts drugs before her children. These assumptions are generally presented as individual deficits and pathologies and there is generally scant attention paid to the environment or setting in which women drug users and their children live (Ettorre, 1992; King, 1993; Paltrow, 2000).[29]

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[28] Campion (1995: 172) cited the following from Koren and colleagues (1989) – 'Of 9 negative abstracts showing no adverse effect only 1 (11 per cent) was accepted, whereas 28 of the 49 positive abstracts were accepted (57 per cent). This difference is significant. Negative studies tended to verify cocaine use more often and to have more cocaine and control cases. This bias against the null hypothesis may lead to a distorted estimation of the teratogenic risk of cocaine.'

[29] These assumptions underlie the discourses about women drug users and their reproductive and parenting roles or work. King (1993) identified an oppositional framework of either individual human rights or communitarianism underlying drugs discourses thereby promoting an adversarial perspective. This also finds its way into the debate about the rights of the woman, the mother and the rights of the child. She argued that an alternative perspective be adopted in reviewing, understanding and responding to women drug users. Campbell (2000) also identified the assumptions and stereotypical images of drug users which underlie the approaches to women drug users – punish and criminalise or more popular recently, the postmodern progressivism – to treat and control. Humphries (1999) and Gomez (1997) examined how these various discourses and assumptions underlie and inform and shape media coverage and the judicial responses to the issue, which then feed off each other and impact on society's views and the body of assumptions that then exists in terms of drug users.

Inundation in drug use has been identified as a key problem. The extent of this inundation is often the key issue in assessment of fit motherhood and parenting capacity. However it is important to point out here that various levels of inundation occur (Faupel, 1991; Rosenbaum, 1981a). Despite this, there is a strong belief that involvement in drug use and inundation and immersion in the life means that 'everything that is supposed to matter becomes secondary to heroin' (Friedman & Alicea, 2001: 103; Sommers *et al.*, 2000). This has been challenged by others who have suggested that 'exceptional mothers' do manage to 'take care of the business' and combine the two careers (Rosenbaum, 1979, 1981a) and that far from being unfit mothers, many were adequate mothers who spent large parts of their day involved with activities other than drug use (Taylor, 1993).

Access to and retention in treatment pose many challenges to drug-using mothers. Children, pregnancy, and motherhood are often cited as major reasons and motivations for women's attempts at behaviour change with regard to drug use and their entry to treatment. Concerns and fears about child care are central (Copeland, 1997, 1998; Copeland & Hall, 1992; Copeland *et al.*, 1993; Friedman & Alicea, 1995, 1999, 2001; Reed, 1985; Rosenbaum, 1981a; Sterk, 1999a; Swift *et al.*, 1996; Woods, 1992). Obstacles encountered include the lack of child care and the prospect of separation from children while in treatment (Rosenbaum, 1981a; Taylor, 1993). Taylor (1993: 140) suggested that asking for help of family or treatment providers may in fact place women at risk of losing their children. In the Irish context, as reported in the first chapter, few if any childcare supports are provided for women with children who wish to access treatment either in the community or residential context. An overview of drug treatment and drug trends in Europe carried out by the European Monitoring Centre confirm these findings. Mothers are reportedly often less likely to access harm reduction services due to the stigma associated with active drug use and involvement in mothering. As a result these services are seen to be failing women (EMCDDA, 2006).

A woman drug user may be reluctant to seek treatment, never mind ante-natal care, because of fears that revealing her drug use status will lead to her children being taken into care (Butler & Woods, 1992; Goodey, 2006; Grella & Joshi, 1999; Lewis *et al.*, 1995; Shea, 1992; Taylor, 1993; Woods, 1992). Women's fears, concerns and perceptions of treatment providers' views of their parenting also dictate in many cases how women access and use services. Friedman and Alicea (2001) noted that their women participants displayed marked resistance to their treatment providers' views and definitions of them as parents. Taylor (1993) highlighted women's fears of social workers particularly. These concerns may increase the likelihood of women minimising their involvement with activities such as drug use in an effort to resist stigma, preserve their repectability, and protect their motherhood role, as noted variously in other studies (Heidensohn, 1996; Thom, 1986, 1987). It has been suggested that treatment programmes for women should particularly focus on working with women towards maintaining and enhancing their relationships with children or re-establishing contacts with children where they have been lost (Wellisch *et al.*, 1993).

Converging discourses of mothering and drug use also present challenges. Significantly these discourses extend to women who have desisted from street drug use. Banwell (2003) described how the construction of methadone mothers has come to the fore. It has been suggested that methadone is the 'mother's drug'. Hollis (1998: 50) noted methadone's reputation as a 'female drug' in some of the literature where methadone use, dependency on treatment and the resulting restriction in movement has been associated with the 'home mother' image. However, as Friedman and Alicea (2001) pointed out the women are perceived as having only moved from being 'deviant' to a 'safer deviance' when maintained on methadone. Adam's study (1999) of social workers' attitudes demonstrated that many workers have little knowledge about methadone and often view it as addictive and merely a substitute for heroin. Recently women on methadone have been described as 'harm minimised mums' (Reid & Hodson, 2005). Mothers in recovery have also merited attention (Carten, 1996).

Women drug users or former users are reportedly always aware of the concerns of others, family members, treatment providers and social services with regard to the welfare of their children. Whereas they often view their families, particularly their mothers, as supportive to them in assisting them with and in some cases temporarily taking over their parenting role (Barnard, 2003; Hogan & Higgins, 2001; Kolar *et al.*, 1994; Richter & Bammer, 2000), they harbour fears and knowledge about the risks of losing their children to the care of others (Boyd, 1999; Friedman & Alicea, 2001; Harbin & Murphy, 2000; Kovalesky, 1997, 2001; Kovalesky & Flagler, 1997; Maher, 1990, 1992; Murphy & Rosenbaum, 1999; Sterk, 1999a; Taylor, 1993). Difficulties can arise in this situation. Considerable conflicts often occur between parents and family members who take over the care of children, grandparents and other relatives may find themselves with little resources and support, financially, psychologically and socially and indeed transgenerational parenting patterns and practices may not be addressed (Barnard, 2003; Family Support Network, 2004; Howe, 2005; Kelley & Damato, 1995; Kelley *et al.*, 2000; Klee, 2002a; Kroll, 2007; McKeown & Fitzgerald, 2006; Murphy-Lawless, 2002; Sheridan, 1995)

Both family and professional support for the women drug users as women and as mothers has also been identified as imperative. It has been suggested (Peterson *et al.*, 1996) that a crucial factor underlying the acceptance of the roles of 'mother' and 'parent' by a woman drug user is the woman's own acknowledgement of her self-worth, self-esteem, effectiveness, self-efficacy, and most importantly, her own needs. However, women are often reluctant to seek support or treatment because of fears of loss of custody (Grella & Joshi, 1999).

Women's fears of social workers are reported and interactions with this particular professional grouping have been described as those that they prefer to avoid (Taylor, 1993). However, interactions with and their experiences, both positive and negative, with treatment and social work services in relation to the motherhood role have been largely ignored. Friedman and Alicea (1995, 2001) reported their women participants' resistance to treatment systems and significantly noted

that the 'women also maintained a critical edge by rejecting the judgements about their performance as women and mothers' (1995: 446).

A number of studies have quite clearly indicated that, although they may often resist conventional ideologies of motherhood along with other categories of mothers, far from failing in their roles as mothers, drug-using women share the parenting values of non-drug-using mothers (Baker & Carson, 1999; Boyd, 1999; Brown, 2006; Colten, 1982; Coyer, 2003; Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993), often demonstrate few differences in parenting styles (Colten, 1982; Leenders, 1992; Sowder & Burt, 1980; Suchmann & Luthar, 2000) and are no more at risk for abusing their children than non-drug users from similar socio-demographic backgrounds (Smarsh Hogan *et al.*, 2006). Alongside this, a recent Australian study (Banwell & Bammer, 2006) focused on women drug users' experiences of childrearing and compared theirs to the experiences of three other groups of women who did not use drugs, women with similar socio-economic backgrounds to the vast majority of women drug users, women experiencing isolation and women with medium and higher incomes. This study found that all of the participants, whether drug users or not, found that living on a low income, experiencing social isolation or being at home with young children presented difficulties on occasion. However, despite the universality of this finding they also concluded that women drug users are often blamed for these difficulties in ways that the other groups of women are not. They also found that drug-using mothers do not receive the same levels of social support.

Being subjected to control, monitoring and surveillance generally and within the treatment and child welfare contexts is often raised and appears to be an issue for drug-using women generally, and mothers specifically (Friedman & Alicea, 2001: 109).

> Fathers, however, are often left unscathed as they are rarely scrutinized, judged or condemned by the public for their inability or failure to assume caregiving or providing roles like mothers.

It is argued that women drug users experience more censure, concern and control than their male drug-using counterparts, whose fatherhood status does not preoccupy society in the same manner (Vogt, 1998).[30]

Buckley (1998a: 254), in her qualitative study of the child protection practice of a social work team in Dublin, similarly observed an almost exclusive focus on mothers throughout the system. She suggested that this focus demonstrated 'a paradoxical element in the way that female parents are generally not only regarded as the "responsible" parents, but inevitably the "appropriate" persons to care for children'. The 'filtering out' of fathers has also been observed (Buckley, 1998b).

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[30] However, alternatively male drug users sometimes do not elicit the same support, treatment opportunities and sympathy that women drug users experience. They do not evoke the same paternalistic concerns (Ettorre, 1992).

Many ethnographies reported women's fears, concerns, and grief about their involvement in motherhood and the care of their children and the occasional temporary or permanent loss of that involvement.

Loss of child custody – the implications

Loss of custody is reportedly one of the major challenges and is often assumed to be the lot of the drug-using woman. Despite the fact that many women drug users continue to live with some or all of their children, loss of custody, it appears, is not unusual experience for women drug users in many jurisdictions (Boyd, 1999; Colten, 1982; Kearney *et al.*, 1994; Maher, 1990, 1992, 1997; Murphy, 1992; Murphy & Rosenbaum, 1999; Nair *et al.*, 1997; Ornoy *et al.*, 1996; Pilowsky *et al.*, 2001; Schilling *et al.*, 2004; Taylor, 1993; Tyler *et al.*, 1997). The term, 'relinquishment', used in the American literature, often refers to circumstances where children are either 'placed in care' or 'removed or taken into care' (Kovalesky, 1997). Apprehension, meaning that children have been 'removed' or 'taken into care' by court orders and the interventions of Child Protective Services or removed informally by others, has been used by another researcher (Boyd, 1996, 1999) to highlight the differences in experience of loss of custody. The term 'non-custodial mother' is used widely in the literature to describe mothers whose children are all living elsewhere, distinguishing their experience from those who have 'complete coresidence' (Knight & Wallace, 2003) with their children or residence with some of their children.

Several qualitative studies of women drug users' experiences offered information about their parenting involvement, lack of involvement with children and the whereabouts of their children (Boyd, 1999; Kearney, 1996; Kearney *et al.*, 1994; Maher 1997; Murphy & Rosenbaum, 1999; Rosenbaum 1981a; Sterk, 1999a; Taylor 1993) as did several Irish studies (Ana Liffey Drug Project/Eastern Health Board Community Care Area 7, 1998; Butler, 1996; Daly, 1986; Keenan *et al.*, 1993; Keogh, 1997; McKeown *et al.*, 1993; O'Connor *et al.*, 1988; O'Neill & O'Connor, 1999; Shanks, 2000; Woods, 1994). Some women have custody of all their children, others live with and care for some of their children, while some are non-custodial mothers with all their children in the care of others (Knight & Wallace, 2003).

Some accounts focused on the experiences of women following the loss of child custody (Akin & Gregoire, 1997; Knight & Wallace, 2003; Kovalesky, 1997, 2001; Kovalesky & Flagler, 1997, Wellisch *et al.*, 1993), examining the impact of their loss of custody, the impact of shame and guilt, the issue of access and visiting and the lack of reunification and loss of contact over time. After such a loss, many women drug users have further children, described as 'replacement babies' (Enos, 2001; Kovalesky, 1997; Murphy & Rosenbaum, 1999; Rosenbaum, 1981a; Sterk, 1999a). They then focus on that new child's care, a process described as 'bracketing' (Enos, 2001). However, they tend not to retrieve the children earlier lost to kinship or non-kinship care. It has also been noted that there are more concerns expressed and subsequent maltreatment allegations in families where a child or children are already in foster care, kinship care or adopted due to prior or

earlier involvement with drug use (Smith & Testa, 2002; Wolock & Magura, 1996). Further studies confirmed that family reunification is rare among women and their children (Smith, 2002; Smith, 2003; Testa, 1997) and as a result few have looked at the issue or process of reunification and the challenges experienced (Carlson *et al.*, 2006; Sterk *et al.*, 2000; Sun, 2000). Such studies have highlighted the stresses, strains and challenges with regard to a range of conflicting emotions and feelings, parenting skills and ongoing stability experienced by women, whose children have lived elsewhere for a time, when reunification occurs.

This loss of children to the care of others has been represented in different ways in the literature. While some accounts of custody loss have discussed the participants' experiences of loss due to interventions by State services or family members or the reluctant relinquishing of their children to others, several other studies emphasised that women drug users give up custody of children in an attempt to reduce harm to and protect their children (Richter & Bammer, 2000). It has been documented that women who lose custody view themselves as total failures as women and mothers (Murphy, 1992; Rosenbaum, 1981a; Sterk, 1999a), often subsequently hiding the fact that they were mothers (Goode, 1999).

Women's loss of children can be seen as a consequence of their involvement in activities not normally associated with 'motherhood and apple pie' (Murphy, 1992). It is interesting to note that a number of authors identified women's relinquishment of their children as a strategy for them to be able to continue their drug use and identified the children as burdens or fetters (Dunlap 1992; Sommers *et al.*, 2000). Some suggested that women give up custody because they want to continue using drugs. In Murphy's study (1992), 68% of the 77 women who participated had lost or given up custody of their children. She viewed this relinquishment of the mother role as both a consequence of drug use and a strategy. Sommers *et al.* (2000: 88) found that 81% of their respondents who had children 'had either lost or given up custody of them'. They also suggested that 'accounts of children getting in the way abounded' (p 92).

> One thing was clear though, when speaking about families, parents, children, lovers, these people were viewed as fetters – fetters on these women's engagement, initially in the high life, and later on, in their missions to obtain drugs and stay high. (p 89)

Some of these studies suggested that women drug users, while not necessarily welcoming the loss of their children, are then free to continue to use drugs and live 'the life'. This argument may conceivably be further supported by the countless studies which demonstrated that after losing child custody women often increase rather than decrease their use of drugs, visit and seek access to their children less and less over time, and rarely fight to get them back. However, these and other studies have also identified the difficulties and bereavement women experience as a result of custody loss. A process of 'numbing out' and 'giving up' has been described as a way of 'handling the hurt' caused by this rupture in their relationships with and custody of children (Kovalesky, 1997). It has also been suggested that many women find it difficult to make a case for themselves and to interact with the child welfare system. Additionally, guilt, shame, resentment and grief often

prevent contact, access and visiting, thereby working against reestablishing relationships and reunification (Kovalesky, 2001; Kovalesky & Flagler, 1997; Wellisch *et al.*, 1993).

The assumption that children of drug-using parents should be placed elsewhere and that parental rights be terminated has underlain several US studies. Some authors actively recommended and advocated for the early termination of parental rights and the removal of their children from the care of drug-using parents (Besharov & Hanson, 1994; McKeganey *et al.,* 2002). McKeganey *et al.* (2002: 242) examined the relevance of the introduction of the Adoption and Safe Families Act (1997), which places an obligation on drug-using parents in the USA to become drug free within 12 months of the commencement of a foster care arrangement. Later calls by McKeganey for the removal to out-of-home kinship or non-kinship care of the children of drug-using parents who fail to become drug free a year after involvement in a treatment episode were reported widely in the Scottish media.[31] However, the risks and harms associated with such an approach and a lack of support for family preservation or reunification approaches have also been emphasised (Klee, 2002f). The children of drug users who come into care have been found in many cases to do so earlier, remain in care longer, experience a larger number of placements and disruptions, experience less access to and contact with their parents during their time in care and are less likely to be reunited with their families (Akin & Gregoire, 1997; Carten, 1996; Fanshel, 1975; Kovalesky, 1997, 2001; Kovalesky & Flagler, 1997; Regan *et al.*, 1987; Smith, 2002; Smith, 2003; Testa, 1997).

Regardless of the opposing representations of custody loss and its aftermath, it is mentioned or assumed in many studies, with only a few focusing on the women's lived experience and the implications of this loss of motherhood (Enos, 2001; Kovalesky, 1997, 2001; Kovalesky & Flagler, 1997; Wellisch *et al.*, 1993). Several noted the increase in loss of custody of children among drug-using women in the USA and stressed the importance of services to prevent loss of custody (Berry, 1996; Carten, 1996; Kovalesky, 2001; Smith, 2002). Kovalesky (2001) examined the increase in out-of home care and looked at the issues arising for women whose children are in this situation. She argued for the importance of mother-child contact and visiting while children are in care, remarking on the deleterious impacts the lack of such visiting can have on the welfare and future development of children. Carten (1996: 214) reviewed the dramatic increase in the US foster care caseload following the 'crack epidemic' in the 1980s and early 1990s and argued that this 'indirectly measures the overuse of out-of-home placement and the slowness of public policy development premised in principles of prevention and family preservation'. Others have examined

[31] McKeganey *et al.* (2002) drew extensively on models from the US as solutions to the difficulties arising and has been reported as calling for what he himself described as a 'draconian strategy' whereby drug-using mothers who do not become drug free a year after giving birth or coming in contact with community care services should have their children placed for adoption ('Kick Habit or lose kids, says expert', *Sunday Times – Times online* – 14/3/2004 - www.timesonline.co.uk; 'Pay Addicts not to have children', BBC News 13/3/2004 – http://news.bbc.co.uk/2/low/uk_news/scotland/3508084.stm. He also called for drug-using women to be paid to use contraception and control their fertility ('Pay addicts to prevent births', *Druglink*, May June, 2004).

the varying trajectories with regard to motherhood and the living arrangements and coresidence of mothers and their children (Enos, 2001; Knight & Wallace, 2003; Schilling *et al.*, 2004).

Also of interest are the studies that aimed to distinguish between those drug-using parents who retain the care of their children and those who do not (Jackson & Berry, 1994; Meier *et al.*, 2004; Pilowsky *et al.*, 2001). To date, in the Irish context the experiences of drug-using women who have lost children to others have not been studied.

In summary, at the end of this section it is important to reiterate that the ideology of motherhood that impacts on all women also has a bearing on drug-using mothers who attempt to manage two careers, often perceived as mutually exclusive. The fear of not living up to the ideology of motherhood and the loss of this motherhood role and their children to the care of others is a constant threat and fear for women drug users. The fear persists for those who maintain the role, while a sense of guilt, failure, loss and self-hatred ensues for those who lose some or all of their children into the care of others. Whereas pregnancy, childcare, motherhood involvement, and appropriate parenting have been largely the impetus for concern, few qualitative studies exist, the preference for medical, psychiatric and psychological research evident. That some women succeed in being adequate parents and maintaining their role while others do not has been seen throughout the literature. The next section will review the research about drug-using parents, their parenting practices and the impact on their children.

Parenting practices and capacity of drug-using parents and impact of parental drug use on children

Increasingly concerns are being raised about the numbers of drug users who are parents and the impact of parental drug use on children. Although much of the research discussed in this section focuses on drug-using parents, the parents in question are almost always mothers (Barnard & McKeganey, 2004; Clarke, 1994; Kearney, 1994). Indeed parenting in the main is socially constructed as the preserve of women (Boyd, 1999; Buckley, 1998a, 1998b, 2003; Friedman & Alicea, 2001; Gillies, 2006; Hogan, 1998; Kearney, 1994; McMahon, 1995; Scourfield, 2001, 2003) and the actions of drug-using fathers elicit far less concern than those of drug-using mothers. Hence when parental drug use is discussed, it is generally women who are the focus of concern.

In addition, the vast majority of families affected by drug use that come into contact with researchers and services are those experiencing a range of adversity or multiple environmental risk factors, often overlapping, most specifically poverty, deprivation, early school leaving, violence, homelessness, mental health challenges, imprisonment and social exclusion generally (Barnard, 1999; Clarke, 1994; Cleaver *et al.*, 1999; Forrester & Harwin, 2006; Gilman, 2000; Grella *et al.*, 2006; Hogan, 1997; Hogan & Higgins, 2001; Howe, 2005; Kandal, 1990; Kettinger *et al.*, 2000; Nair *et al.*, 2003; Sheridan, 1995; Smarsh Hogan *et al.*, 2006; Suchman & Luthar, 2000; Woods, 2000a).

During the 1970s in the US, Densen-Gerber & Rohrs (1973: 694) claimed that 'addiction must be designated as a prima facie criterion of unfitness as a parent'. During the 1980s, Colten (1982: 79) noted how assumptions impact on research carried out in this field.

> Addicted parents are a priori child neglecters, at best, and child abusers, at worst; and that addicted parents and their children are isolated from the involvement and input of other caring adults.

In the UK, Perry (1987) observed how assumptions about drug-using mothers impacted on a legal decision about fitness to parent. During the 1990s, Campion (1995) identified a range of assumptions held about drug-using parents' fitness to parent, while in the early 21st century McKeganey *et al.* (2002) argued that the children of drug-using parents are likely to be neglected and exposed to a range of adversity arising from the lifestyle associated with drug use.

The children of drug users have been viewed or studied largely from two perspectives, on the one hand as a force, as stressors or motivators for change in their parents' lives, as we have seen in a number of studies mentioned earlier in this review. On the other hand they are viewed as a focus of concern in their own right, without regard to the well-being of the parents (Colten, 1982; Eldred *et al.*, 1974). Variously children of drug-using parents have been described as 'drug exposed', 'drug affected' and 'drug endangered' (Altshuler, 2005) and are seen to be in grave risk as a result of their parents' involvement in drug-taking. Children of drug-using parents have been claimed to be invisible (ACMD, 2003; Barnard, 1999; Barnard & Barlow, 2003; Kroll & Taylor, 2000, 2003; McKeganey *et al.*, 2002; Powis *et al.*, 2000; Tunnard, 2002a) and the levels of denial and secrecy among parents, their children and family networks, and isolation often due to stigma and shame, have been identified (Banwell & Bammer, 2006; Barnard & Barlow, 2003; Hogan, 2003; Hogan & Higgins, 2001; Kroll, 2004, 2007; Kroll & Taylor, 2003; Murphy-Lawless, 2002). Hence the issues raised by studies in the addiction and child protection field, that have tried to estimate the numbers of children affected, warrant attention.

Much of the research on this topic has been carried in the USA and in the UK. However, the pitfalls of using US research in discussing the UK or Irish situation have been noted (Forrester & Harwin, 2006; Street *et al.*, 2004; Tunnard, 2002a). The policy context of the US 'war on drugs' and 'zero tolerance' approach to drug use during pregnancy or among drug-using mothers differs to the European policy context which leans more towards harm reduction and family preservation (Klee *et al.*, 2002).

While all the reviews focus on a wide range of studies and literature, researchers examining these issues have identified some methodological and definitional difficulties (Barnard, 2005a; Deren, 1986; Famularo *et al.*, 1992; Hogan, 1998; Kroll & Taylor, 2003; Mayes, 1996; McKeganey *et al.*, 2002; Smarsh Hogan *et al.*, 2006; Tunnard, 2002a). Firstly, the numbers of parents and children

potentially affected are simply unknown although a number of suggestions and estimates have been offered.

Secondly, the visibility of some drug-using parents, particularly those experiencing problems, and the invisibility of others suggests that a somewhat skewed picture of the experiences of all drug users emerges. Several studies have focused on the relationship between parenting and drug use in child protection register, court or probation-based populations. In these studies focusing on parents who are already identified as abusing and/or neglecting their children, it is often found that they have concurrent substance use problems (Chaffin *et al.*, 1996; Cleaver *et al.,* 1999; Famularo *et al.,* 1992; Forrester, 2000; Forrester & Harwin, 2004, 2006; Hampton *et al.*, 1998; Hayden, 2004; Kelleher *et al.*, 1994; Murphy *et al.*, 1991; Rickford, 1996).[32] Estimates of the prevalence in child welfare services range from at least 40% to 80% in the US studies (Grella *et al.*, 2006; Wilke *et al.*, 2005; Young *et al.*, 1998) and between 20% and 62% in the varying UK studies (Cleaver *et al.*, 1999; Kroll, 2004). A small Irish study recently reported that ten of 20 families in contact with child protection services were identified as affected by parental alcohol or drug use (Buckley *et al.*, 2007). Fewer studies have examined those who use street drugs or those in treatment who are not in contact with child protective services. Consequently, much less is known about the childrearing and parenting patterns of drug users in the general population and the development of drug users' children generally because those parents and children do not necessarily come to the attention and monitoring of the authorities.

Thirdly, when reviewing studies we are unlikely to be comparing like with like. Some studies focused on the experiences of parents currently using drugs while several have recruited methadone maintained parents or parents in the course of treatment as their key informants. Others recruited parents, key workers and family members while a few exceptions also interviewed children (Barnard & Barlow, 2003). Some studies assessed and measured similarities and differences on a range of issues between different groups, drug-using parents and non-drug-using controls, using qualitative or quantitative methods (Banwell & Bammer, 2006; Colten, 1982; Hogan & Higgins, 2001; Kandel, 1990; Smarsh Hogan *et al.*, 2006; Suchmann & Luthar, 2000; Williams-Petersen *et al.*, 1994). By contrast other qualitative studies, such as ethnographies, have attempted to gather data through observation and open-ended interview using more interpretative frameworks (Baker & Carson, 1999; Goode, 1999; Klee *et al.,* 1998; Klee *et al.,* 1998; Rosenbaum, 1981a; Taylor, 1993).

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[32] One often quoted study, that of Famularo *et al.* (1992), identified some clear connections between child maltreatment and substance use in their sample of individuals on probation and court registers for child maltreatment, a sample already implicated as child maltreaters or abusers. This article commenced and concluded with a clear caveat about the dangers of over-interpretation of the findings and about the inappropriateness of generalising from the study's findings to the entire substance-using population. However despite this, Famularo *et al.*'s work is almost always referred to as conclusive (Alison, 2000; Kroll & Taylor, 2003) and in my literature search and perusal, the authors' caveats were only mentioned in one review focusing on this issue (Tunnard, 2002a: 23).

Fourthly, different definitions have been employed and it has been pointed out that some disregarded gender issues in primary caregiving and the environmental impacts and socio-economic disadvantage, as mentioned earlier (Hogan, 1998; Mayes, 1996).

Fifthly, the issue of conflicting accounts among different groups of participants responding has also attracted some concern. The veracity of drug users' accounts generally but particularly with regard to parenting has attracted some comment (Barnard, 2005a; Comberton, 1989; McKeganey, 2003; McKeganey *et al.*, 2002; Maher, 1997; Rosenbaum, 1981a; Taylor, 1993). Despite this, many reviewers relied on ethnographic accounts and self reports of women drug users to provide the most valuable data about parenting while using street drugs. Suchmann and Luthar (2000: 1425) noted the issue of assumed underreporting of difficulties by drug-using mothers.

> Although the accuracy of maternal reports was not cross-validated, there was no evidence of marked underreporting of parenting problems by addicted mothers...addicted mothers reported significantly more problems than comparison mothers in two of the three parenting dimensions.

An earlier study had also remarked that women drug users express more doubts about their adequacy as parents (Colten, 1982). In addition, most studies, qualitative and quantitative, of the experiences of drug-using parents and the impact on their children have recruited the parents themselves as key informants.

Finally, another difficulty emerges as a result of the focus of research. Tunnard (2002a: 22) pointed out that there is in fact little research on the day-to-day lives of the children of drug-using parents and what there is tends to focus on children who are already living apart from their parents.

The research evidence is inconclusive and often contradictory. Focusing on the post-natal experience of the children of drug-using parents, Hogan (1998) highlighted the inconclusive nature of the evidence about their experiences and their social and psychological needs. She recommended that further work with a more fine-tuned methodology be undertaken to explore these needs, particularly in the light of the social context of their experience. Others also alluded to the incomplete picture and inconclusive evidence in this regard (Buchanan & Corby, 2005; Street *et al.*, 2004; Tunnard, 2002a). Indeed, several authors (Famularo *et al.*, 1992; Hogan & Higgins, 2001) offered caveats with regard to their methods, which were not taken on board in later reviews.

However, there are issues raised in many studies that have implications for drug treatment, social work practice, therapeutic endeavours and the management and administration of drug services, prison regimes and child protective environments. Many concerns about drug-using parents and their children have been identified. These range from the inability to provide consistent care to the risks of parental death and parent-child separations.

Parental drug use and its impacts

Several texts concerned with substance use and childcare have been published with a range of interventions and contributions to this debate (Barnard, 2005b, 2006; Harbin & Murphy, 2000; Kroll & Taylor, 2003). Klee *et al.* (2002) added a thick volume of essays and articles on drug use and motherhood to their earlier empirical studies of women drug users' experiences of pregnancy and drug users as parents (Klee, 1998; Klee & Jackson, 1998; Klee & Lewis, 1996; Klee *et al.*, 1998; Lewis *et al.*, 1995). The stereotyping of drug-using parents has also been a focus of some studies (Ford & Hepburn, 1997; Kandal, 1990; Klee, 1998; Klee & Jackson, 1998; Klee *et al.*, 2002; Leenders, 1992; Lief, 1985). Parental, particularly maternal drug use, is often cited as a major characteristic of child welfare or child protection caseloads and social work practice in this regard has begun to merit some attention (Adams, 1999; Buchanan & Corby, 2005; Butler, 1996; Curtis & McCullough, 1993; Daly, 1986, Forrester, 2000; Forrester & Harwin, 2004, 2006; Hampton *et al.*, 1998; Harbin & Murphy, 2000; Hayden, 2004; Klee *et al.*, 2002; Kroll & Taylor, 2000, 2003, 2006; Rickford, 1996; Scottish Executive, 2001; Smith, 2003; Street *et al.*, 2004). Several qualitative and ethnographic studies focused on the lives and lived experience of women as mothers and have contributed to our knowledge of women in this challenging situation (Adams, 1998; Baker & Carson, 1999; Bolla, 1996; Boyd, 1996, 1999 Kearney *et al.*, 1994; Rosenbaum, 1979, 1981a; Taylor, 1993, 1997). Indeed it is argued by some that studies of this nature reveal much about parenting and motherhood and are increasingly necessary (Boyd, 1999; Kearney *et al.*, 1994; Mayes, 1996; Suchmann & Luthar, 2000). Policy interest in recent years has also been significant (ACMD, 2003; NACD, 2005; Scottish Executive, 2001).

In Ireland there has been increasing interest in the needs of children of drug-using parents and the impact of drug use on families (Bowden, 1997a; Duggan, 2007; Family Support Network, 2004; Hogan, 1997; Hogan & Higgins, 2001; McKeown & Fitzgerald, 2006; Murphy & Hogan, 1999; Shanks, 2000; Watters & Byrne, 2004; Woods, 1994, 2000a). One Irish study (Hogan & Higgins, 2001) identified four key areas in which parental drug use impacted on children. These were disruptions to parenting and care, exposure to parents' lifestyles, children' emotional well-being and their academic progress. Another study recently identified the issue of limit setting and discipline as a key issue among drug-using parents but also in the wider families where drug use is an issue (McKeown & Fitzgerald, 2006)

Several reviews of the literature identified the main concerns, revealing that studies variously look at the impact of parental drug use on child development; the effects of drug use on parenting capacity; parenting styles of drug-using parents; and child abuse or child maltreatment among children of drug-using parents (Barnard, 2006; Barnard & McKeganey, 2004; Davis, 1990; Deren, 1986; Hogan, 1998; Howe, 2005; Kroll & Taylor, 2003; Mayes, 1996; Tunnard 2002a). More recently, a fifth area has emerged which concerns the issues and dilemmas for social workers when assessing risk with drug-using parents (Billingham, 1999; Buchanan & Corby, 2005;

Buchanan & Young, 2002; Buckley *et al.*, 2006; Cleaver *et al.*, 1999; Forrester & Harwin, 2004, 2006; Murphy & Harbin, 2000; Taylor & Kroll, 2006).

As mentioned above, there is consensus abroad however among practitioners and research that generally confirms that parental drug use, either by a father or mother or by both parents, presents a range of challenges for parents, their children and for the practitioners who work with them. It has also been suggested that it can have a transgenerational component (Barnard, 2003; Howe, 2005; Klee, 2002a; Kroll, 2007; McKeown & Fitzgerald, 2006; Sheridan, 1995).

It has been maintained by some commentators that parental drug use *per se* does not equate with poor parenting or unacceptable standards of parenting, that not all drug users mistreat or abuse their children (Barnard, 1999; Billingham, 1999; Buchanan & Corby, 2005; Campion, 1995; Murphy & Harbin, 2000; Street *et al.*, 2004) or indeed it is not necessarily a cause of poor child development (Pilowsky et al., 2001). However, while many studies pointed out that drug use *per se* does not equate with poor parenting practices, skills and capacity, they generally have presented evidence to the contrary. Studies have suggested a strong link between community care caseloads and substance use in the UK (Forrester, 2000; Forrester & Harwin, 2006; Hayden, 2004; Rickford, 1996). Many of the North American studies have demonstrated links between maternal drug use and child maltreatment and the child welfare system (Ammerman *et al.*, 1999; Barth, 1994; Besharov & Hanson, 1994; Black & Mayer, 1980; Curtis & McCullough, 1993; Dore *et al.*, 1995; Famularo *et al.*, 1992; Jaudes *et al.*, 1995; Kelleher *et al.*, 1994; Leventhal *et al.*, 1989; Leventhal *et al.*, 1997; Magura & Laudet, 1996; Murphy *et al.*, 1991; Olsen *et al.*, 1996; Sheridan, 1995; Wasserman & Leventhal, 1993). Most studies of maternal addiction or drug use and parenting commence with the general hypothesis that parental drug use compromises parenting and adversely affects the children's psychosocial and cognitive development. However as Smarsh Hogan *et al.* (2006: 146) succinctly pointed out:

> there is no way to know for certain how many parents from any population are substance users or how many parents from any population maltreat their children. Likewise, there is no way to know for certain how many substance-using parents abuse or neglect their children. ... existing data have not established a causal relationship between substance use and child abuse.

Research has variously identified that problematic alcohol use among parents often impacts directly on families and on the needs, care, welfare and safety of their children and the stability of their later lives in adolescence and adulthood (Brisby *et al.*, 1997; Butler, 2002d; Dube *et al.*, 2001; Tunnard, 2002b; Velleman, 1993, 1996; Velleman & Orford, 1993, 1999; Wegscheider-Cruse, 1981; Woititz, 1990; Wolin & Wolin, 1993). Specific family dynamics, taboos with regard to discussions about the alcohol problem and the importance of secrets in the family have been seen as characteristics of the 'alcoholic family' (Thombs, 1999). The difficulties experienced by children of those with alcohol problems are not unique however (Brisby *et al.*, 1997; Butler, 2002d; Velleman & Orford, 1999).

Specifically a number of texts have reviewed the smaller research base to date about drug-using parents, their parenting practices and the impacts, potential and actual, of their drug use on their children (Barnard & McKeganey, 2004; Bauman & Dougherty, 1983; Bauman & Levine, 1986; Davis, 1990; Deren, 1986; Hogan, 1998; Kandal, 1990; Kroll & Taylor, 2003; Mayes, 1996; Tunnard, 2002a; Zuckerman, 1994). These studies and others maintained that parental drug use does impact on children in a number of ways (Hogan, 1997, 1998; Hogan & Higgins, 2001; Klee, 1998; McKeganey *et al.*, 2002; McKeganey *et al.*, 2003; Reid *et al.*, 1999). These potential impacts range from children's exposure to drugs *in utero*, withdrawals or NAS, higher risk of mortality, prematurity, low birth weights to developmental and behavioural problems, abuse, neglect, and substance use problems in adulthood. In addition, while findings similar to those of alcohol-using parents and their children are reported, the added difficulties and stigma associated with the problematic use of an illicit rather than licit drug is evident in studies of drug-using parents. The illicit nature of the drug and the activities associated with its procurement may somewhat exacerbate difficulties for parents and children.

Significantly, it has been noted particularly in studies which have examined the needs of children of alcohol and drug users simultaneously that there is more tolerance or acceptance of alcohol rather than illicit drug use, even while it has been shown that alcohol use may have as many or even more deleterious effects on children than drug use (Forrester, 2000; Forrester & Harwin, 2004; Murphy *et al.*, 1991; Murphy & Harbin, 2000). In his study of parental substance use and the child protection register in a London area, Forrester (2000) found that most social workers rated illicit drug use as 'very concerning' while rating problematic alcohol use as 'moderately concerning'. Forrester and Harwin (2004: 128) suggested that their research findings and those of others point towards the over optimistic responses and attitudes of social workers towards those with alcohol problems. In a later publication (Forrester & Harwin, 2006), they found that drug use was strongly linked to care proceedings among the families in their study, 41% of all children of drug-using parents compared with 21% of children where alcohol only was a concern.

That drug-using parents are often unable to provide consistent basic care to their children has been identified in many studies (Barnard, 2006; Barnard & Barlow, 2003; Hogan, 1998; Hogan & Higgins, 2001; Kroll & Taylor, 2003; McKeganey *et al.*, 2002). In families where drug use is an issue, often the main carer using drugs is also a single parent. As a result children may have no access to a protective non-using adult (Forrester & Harwin, 2006). The quality of care may be variable and dependent on whether parents are stable and managing their drug use and parenting roles, are using chaotically consistently or are periodically in crisis (Campion, 1995; Kroll & Taylor, 2003; McKeganey *et al.*, 2002). Parents' preoccupation with drugs and the purchase and use of drugs may divert their attention, time and financial and other resources away from their children's needs and the role of parenting (Hogan & Higgins, 2002; Kearney *et al.*, 1994; Rosenbaum, 1979, 1981a). This may have implications for meeting children's needs for food, clothing and shelter. Neglect has been associated with parental opiate use in a number of studies (Alison, 2000; Bays,

1990; Famularo *et al.*, 1992; Forrester, 2000; Kroll & Taylor, 2003). Their children's safety and protection may also be compromised by their immersion in the life associated with drug taking (Kroll & Taylor, 2003; McKeganey *et al.*, 2002). It may also impact on their capacity to support their children's emotional and educational development (Hogan & Higgins, 2001).

Poor parenting skills, emotional detachment, coldness and lack of supervision have been reported in some studies of drug-using parents and families, as has extreme discipline (Cleaver *et al.*, 1999; Schuler *et al.*, 2002). Ineffective and inconsistent responses to children, sometimes authoritarian and extreme discipline that could be defined as abuse and other times a 'laissez-faire attitude' constituting neglect have been observed among drug-using mothers (Bauman & Dougherty, 1983; Beckett, 2003; Deren, 1986; Hogan, 1998; Kandel, 1990; McKeown & Fitzgerald, 2006; Mayes, 1996; Suchmann & Luthar, 2000). It has been reported on the other hand that women drug users are less strict and less physically punitive with their children than their non-drug-using counterparts (Colten, 1982). Overcompensation has also been noted (Kearney *et al.*, 1994; McKeown & Fitzgerald, 2006).

Drug-using parents are reported to be less available, both physically and emotionally, to their infants and children (Bernstein *et al.*, 1984; Cleaver *et al.*, 1999; Hogan & Higgins, 2001; Howe, 2005; Schuler *et al.*, 2002). Parents' availability and responsiveness to their children may be affected by their experiences of intoxication and withdrawal and their general involvement with drugs and the life. Moodiness, disconnectedness and disinterest have been reported (Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993). The issue of ambivalence is an interesting one that has been raised by drugs researchers and child advocates alike. Wellisch and Steinberg (1980:810) suggested that

> When attitudes have been investigated, it has been consistently observed that addicts want their babies, but also ambivelently resent them (Singer, 1974; Nichtern, 1973).

As discussed earlier, the link between maternal drug use and parental involvement or lack of involvement is often viewed as evidence of lack of care and the perception of children as burdensome among drug-using parents. Suchmann & Luthar (2000: 1424) pointed out that while some ethnographers reported what they described as ambivalence among many drug-using mothers about bearing and rearing children (Kearney *et al.*, 1994; Rosenbaum, 1981a; Taylor, 1993), they also identified the women's efforts to leave their children in the care of others, such as family members or neighbours for short or lengthy periods, in order to protect them from the impact of their drug use and lifestyle. Others have also suggested that this sort of action is often a strategy to attempt to reduce harm and protect children (Richter & Bammer, 2000). Perhaps, also it is necessary to reflect on this issue of ambivalence and raise questions about mothering and ambivalence in general (Holloway & Featherstone, 1997).

Parents' involvement in illicit drug use and associated lifestyle may expose children to a range of

experiences considered problematic (Hogan & Higgins, 2001a, 2001b; McKeganey *et al.*, 2002). Witnessing the purchase of drugs, the use of drugs, accompanying their parents to unsafe situations, witnessing criminal activity, arrest and imprisonment may cause concern to children. Hogan & Higgins (2001b: 129) however found that while a 'sizeable minority' (40%) or 20 children involved in their study had witnessed or been exposed to their parents' drug-using or related activities, 60% or 30 children had not. Safety and protection from others using drugs in these contexts has been identified as a concern, especially where homes are being used as meeting places for groups of drug users or as a base for dealing. Another issue in terms of the children's health and wellbeing is the presence of dangerous drugs, the storage of methadone and accessibility of injecting paraphenalia in the home.

Parents have been found to be often less involved with their children's involvement in education and progress at school (Hogan & Higgins, 2001a). This may be largely due to the value attached to education within their family systems or to their own difficulties with literacy and early school leaving, noted in Chapter One.

Parents' experience of stigma and isolation within their families and communities may impact on children, who are sometimes cut off from their extended families and support from their communities. Lack of family or friendship support has been identified as creating risks for drug-using parents and their children (Famularo *et al.*, 1992). It has also been suggested that the children of drug-using mothers 'may also suffer, not necessarily at the hands of their mothers, but because their mothers are heroin addicts confronted with vanishing material and social resources and the rejection and disdain of others' (Colten, 1982: 88). The drug user involved in parenting is often vilified and demonised to the extent that a child's view of her/his parent may be impacted upon by the views and attitudes of police, social workers, drug treatment providers and the public at large of her/his parent or parents (Klee, 2002a).

Alongside greater feelings of inadequacy, some studies have reported that drug-using mothers have more fears about their children's futures and they believe that parents may not have as much control as outside sources (Colten, 1982). This may indeed relate to their own lives, childhoods and the risks to which they themselves were exposed.

Parents are often separated in the short or longer term from their children due to hospitalisation, participation in residential drug treatment, or imprisonment (Enos, 2001; Hogan, 1997, 1998; Hogan & Higgins, 2001a; Kroll & Taylor, 2003; Lewis, 2004; Schilling *et al.*, 2004; Smith *et al.*, 2004). The reluctance of drug-using mothers particularly to leave their children while in treatment has been identified (Rosenbaum, 1981a; Taylor, 1993). However despite that, few services facilitate or welcome children into residential treatment programmes. Prisons have been found to be more proactive in this regard with several prisons including, the Dochas Centre in the Mountjoy

complex in Dublin, having facilities for infants to accompany their mothers.[33] The vulnerability of children affected by the incarceration of their drug-using mothers has begun to attract some attention also (Hanlon, Blatchley *et al.*, 2005), the results revealing resilience and little deviance or maladjustment among this group despite adversity and suggesting the need for increased supports for the alternative carers of these children and young people.

It was noted earlier that many women drug users were often living apart from and uninvolved in the care of their children and that separation and loss of custody were highlighted as the main challenges facing the drug-using mother. Children of drug-using parents are it seems more likely to be taken into care (Forrester & Harwin, 2006; Howe, 2005; Keen & Alison, 2001; Kelley, 1992). Substance-using mothers involved with the child welfare system are more likely to lose custody than non-using mothers (Grella *et al.*, 2006; Marcenko *et al.*, 2000). This issue of separation and child placement has been highlighted as impacting greatly on the experience of the children of drug-using parents with evidence that out-of-home placement puts children at high risk of adverse outcomes (Kovalesky, 1997, 2001; Pilowsky *et al.*, 2001; Richter & Bammer, 2000; Taylor & Kroll, 2006). Parents often place their children with other family members or lose custody of their children to kinship or non-kinship carers (Barnard, 2003; Kroll, 2007; Nair *et al.*, 1997; Tyler *et al.*, 1997). The many drawbacks involved for children in out-of-home care were highlighted earlier.

Parents' health, welfare and longevity is often affected by drug use and its associated health risks, HIV and Hepatitis infections, overdose, accident and injury. The risk of violence is often present. Experiences of domestic or intimate partner violence among drug-using women and the impact on their children have also merited limited attention (Cleaver *et al.*, 1999; Forrester & Harwin, 2006; Irwin, 1995; Kroll, 2004; Sales & Murphy, 2000).

The potential risks and harms to infants and children of drug-using parents therefore are considerable and have been identified in many studies. They have varying consequences for children's sense of emotional security and attachment (Howe, 2005; Kroll & Taylor, 2003). Children may harbour anxieties, fears, concerns and worries about inconsistency in their parents' behaviour, lack of routine, uncertainty about the future, their parents' health, and their own care arrangements in the short and longer term (Hogan and Higgins, 2001a; Kroll & Taylor, 2003). Children may be affected by these uncertainties and fears (Barnard & Barlow, 2003; Howe, 2005) as a result taking on early caring roles, parentification, growing up fast and taking on adult responsibilities (Aldridge & Becker, 1993; Bancroft *et al*, 2004; Barker & Hunt, 2004; Barnett & Parker, 1998; Becker *et al.*, 1998; Bekir *et al.*, 1993; Boszormenyi-Nagy & Spark, 1973; Kelley *et al.*, 2007; Laybourne *et al.*, 1996) or worrying or grieving about parents' health and risky behaviours (Bowden, 1997a). The very real threat of losing their parent through death is often present and many children of drug-using parents may experience this loss (Bowden, 1997a; Woods, 1994). Underperformance at

[33] Many women chose to organise an alternative carer outside of the prison context for their children rather than have their child accompany them into the prison (Personal Communication, Probation Officer).

school, poor concentration and work completion have been reported and teachers have reported that children are often 'clingy' (Hogan & Higgins, 2001a; Kroll & Taylor, 2003). Externalising and internalising behaviours have been identified (Bowden, 1997a; Kroll & Taylor, 2003). Sleeping problems and bed wetting have been reported among some children. Some research (Catalano *et al.*, 1998; Howe, 2005; Lloyd, 1998; McKeganey *et al.,* 2003) suggested that children of drug users, among others, are particularly at risk of delinquent and anti-social behaviour, impaired development and psychopathology in adulthood. There are always concerns about children's future involvement in drug taking, for example according to Howe (2005: 188) 'the children of drug or alcohol using parents are themselves at four to tenfold risk of substance abuse'.

Some effects are associated with exposure to drug use, others with exposure to the lifestyles associated with drug use although it is generally agreed that few, if any, studies have been able to identify the unique effects of substance use upon parenting or children. While comparison studies of drug-using and non-drug-using parents have been carried out in an effort to identify, assess and determine the unique effects of substance use on parenting, attitudes and behaviour and the outcomes for the children of drug-using parents (Colten, 1982; Hogan, 1998; Hogan & Higgins, 2001a; Suchmann & Luthar, 2000), they have often found minimal differences between the two groups and in others they have been inconclusive. Furthermore, as emphasised earlier, the added stresses, strains and environmental factors which impact on drug users' lives means that separating out drug use from living in poverty stricken and adverse conditions is difficult (Barnard & McKeganey, 2004; Deren, 1986; Hogan, 1998, Nair *et al.*, 2003). Other issues arising – socio-demographic factors, poverty (Murphy, 1992), age at first becoming a mother (Kandel, 1990) may contribute to parenting difficulties and problems at least as much if not more than maternal addiction *per se* (Suchmann & Luthar, 2000). Additionally, these studies have mostly been carried out in treatment or clinical populations of substance users, who tend to be those experiencing a range of difficulties. The potential for child maltreatment or abuse has also been identified among those with a previous history rather than current substance use (Ammermann *et al.*, 1999; Famularo *et al.*, 1992).

In summary, studies present varying findings, some suggesting severe damage physically, psychologically, emotionally and developmentally to the children of drug-using parents whereas others identify protective factors such as family and community support, one non-drug-using parent and drug treatment involvement. Others have focused on the protective strategies adopted by drug-using parents in their attempts to combine their careers in drug use and parenting. The ACMD report, *Hidden Harm*, proposed that reducing the harm to children associated with parental drug use should become a key objective of policy and practice (ACMD, 2003).

Protective factors and strategies

As Kroll & Taylor (2003: 15) stated 'for many children living with parental substance misuse, life can be difficult and frightening', however they also cautioned that we cannot assume that all

children in such situations are affected negatively. While there are negative effects of parental drug use and many difficulties arising, protective factors exist also and have to be acknowledged. While Tunnard (2002a) referred to the 'bleak picture' offered by many of these studies, it is also useful to look at some of the strategies employed by parents to either reduce harm or protect children.

While much of the research on protective factors has been carried out where alcohol use rather than drug use is a problem, many of the findings of these and drug-focused studies offered insights into this issue (Kroll & Taylor, 2003). Individuals and families, drug-using parents and their children cope in a range of ways, and with varying degrees of success, while drug use continues. As already noted, some parents manage to maintain a balance between the two activities, parenting and drug use, but this however has been identified as the greatest challenge for such parents (Campion, 1995; Hogan & Higgins, 2001a; Kearney *et al.*, 1994; Suchmann & Luthar, 2000). Where there is one parent who does not use drugs, where there is an extended family support network, and where there are formal and informal social networks and educational opportunities, protective factors increase for the child or children in question. These may protect them from current or long-term adversity.

It is suggested that children experience less difficulties, both in the short and long-term, where there is minimal disruption to their lives. The fewer disruptions in living arrangements, caretakers, the maintenance of family rituals, consistent daily routines are recognised as offering stability, continuity and consistency, even where drug use or alcohol use is taking place (Butler, 2002d; Velleman & Orford, 1999).

Protective strategies employed by drug-using women have been variously described through this review. These protective strategies involve protecting themselves, their identity, their reputations and their drug use. Studies have sought to identify the protective strategies reportedly employed by parents, usually mothers, in order to protect their children from what might be described as the potentially damaging and dangerous effects of their drug use (Barnard & Barlow, 2003; Hogan & Higgins, 2001a, 2001b; Kroll & Taylor, 2003; Richter & Bammer, 2000; Rosenbaum, 1981a; Taylor, 1993). Hogan & Higgins (2001b) revealed how their participants describe protecting their children from witnessing their drug use. Richter & Bammer (2000) described a range or 'hierarchy' of protective strategies employed which occur in much of the literature. This hierarchy of seven strategies included ceasing drug use, entering treatment, maintaining a small stable habit, shielding children from drug-related activities, keeping the home as safe and secure as possible, staying out of jail and finally, if the children's needs are still not being met, placing them with alternative carers, such as family members or foster carers and maintaining as active a parenting role as possible through access and visiting. Klee *et al.* (1998) also described how parents reduced their use, entered treatment or ceased use in order to protect their children.

Low levels of family conflict; clarity and consistency with regard to rules, limit setting and discipline;

a reasonably regular pattern to family life; open acknowledgement that the parent has an drug or alcohol problem and the involvement of a stable or non-using adult (Brisby *et al.*, 1997; Butler, 2002d; Kroll, 2004; Kroll & Taylor, 2003) are all potential protective factors against harm in the longterm. However it also must be recognised that individual vulnerability varies, where some children display considerable resilience to the disruption caused by drug taking or drinking (Bancroft *et al.*, 2004; Butler, 2002d; Velleman & Orford, 1999). Individual 'protective mechanisms' (Daniel *et al.*, 1999; Rutter, 1995) and characteristics that promote and foster resilience have to be acknowledged by both researchers and practitioners.

Bancroft *et al.*'s study (2004) explored the experiences of 38 young people aged 15 – 27 years, who had either one or two parents with an alcohol or drug problem. Despite major difficulties experienced at times while growing up, they described the ways in which they managed to get by on a day-to-day basis, their accounts however suggesting 'no smooth passages into adulthood, not least because their childhoods were themselves characterised by adult responsibilities and many changes and transitions' (ibid: x). They did report that maintaining some control over their environment; support, interim care and even fostering arrangements from extended family members, most often their grandmothers; friendships; goal setting, future plans and involvement in education; and ultimately moving towards independent living made important contributions to dealing with their situation.

Despite the many potential negative outcomes of parental drug use and its impact on children or the impact of exposure to their parents' drug use, studies have also sought to identify the characteristics of those who succeed in maintaining custody of their children (Knight & Wallace, 2003; Meier *et al.*, 2004; Pilowsky *et al.*, 2001; Schilling *et al.*, 2004).

Drug-using mothers in treatment programmes involved with child welfare services were younger, had more children, more economic problems, were more likely to have a history of physical abuse and to be referred to treatment by the criminal justice system or other services than their counterparts in treatment with no child welfare involvement (Grella *et al.*, 2006). Parents with children in care or children living elsewhere have often been found to be those with the greatest range of difficulties (Meier *et al.*, 2004). Those who maintain their role often use drugs less often and live in better circumstances than those who do not. Women who did not live in their own home, had less education and used multiple drugs were more likely to have lost custody of one or more of their children (Schilling *et al.*, 2004). One US study reported that those parents living with their children tend to be female, as mentioned throughout this review, are more likely to have health insurance, thereby indicating some socio-economic advantages, tend to engage in lower risk or no risk drug practices, and have better health status, for example, are either HIV negative or HIV positive but asymptomatic (Pilowsky *et al.*, 2001). They also have more family support, both formal and informal, their children having grandparents involved in their care and often minimising risks of exposure to drug use and its associated lifestyle (Dumas, 1992; Hogan & Higgins, 2001a). Family

support has been recognised as crucial despite the challenges presented by the tensions, difficulties and differences that can emerge between drug users and their families around the care of their children (Barnard & Barlow, 2003; Hogan & Higgins, 2001a; Kroll, 2007; Laybourne *et al.*, 1996).

The answers to the question 'Why do some parents continue to live with their children?' may offer important guidelines for practice principles. Looking at the negatives involved and avoiding the strengths and potential strengths of individuals may be crucial in terms of both assessments of parental capacity and interventions with such families (Buckley *et al.*, 2006: 101). Tunnard (2002a: 22) pointed out that it is unclear as to whether placement decisions about children being placed in out-of-home care stem from the difficulties experienced by children or parents rather than from society's attitudes to parents who use drugs.

In summary, as Kroll & Taylor (2003: 53) asked, 'What can we make of all this conflicting and often confusing research?' This question is a very important one, quite simply because it is a reminder that we need to both take account of and critique the research minutely to see what can possibly be adopted as best practice. Tunnard (2002a: 45-46) ended her review with

> a note of caution ... about the weaknesses of much of current social care research ...not to deter social care professionals from reading and using research studies ...but to remind readers that they need to approach research with an enquiring mind.

It could be argued that the research is neither contradictory nor conflicting but that there are simply different findings in different studies among different groups of drug-using parents in different locations, jurisdictions, policy environments and environmental conditions. Different researchers may start out with different research questions and concerns. Research participants are recruited in a variety of different manners. Small glimpses of information about drug users' involvement in parenting and about the children of drug-using parents have been extrapolated from studies of a range of issues. This range of difference highlights the methodological problems that emerge at every turn in attempting to identify the unique and exact relationship that exists between drug use and parenting. In positivistic terms, there are simply so many variables and factors impacting on the picture emerging.

As noted in some of the literature reviewed, child welfare and protection concerns are coming to the fore about drug users' parenting styles, practices and capacity and the impact of parental drug use on children. Perhaps this is why the issues with regard to interactions with services and assessments, reviewed below, are so important.

Child Protection – Social Work Practice and Assessment

> Work with drug-using parents and their children has always been a difficult and sensitive areas of practice, and has inevitably been a process of trial and error. (Kearney, 1994: 6)

This section will review some of the recent literature that concerns the issues and dilemmas for social workers when assessing risk with drug-using parents. Dilemmas for social workers documented in the literature include challenges with regard to assumptions, engagement with drug-using parents, assessment, confidentiality, knowledge about drugs and substance use issues, interagency cooperation and gaining access to children's perspectives and views. Firstly, it will look at some of the evidence about social workers' attitudes and practice with drug-using parents, leading to the conclusion that assessment frameworks are important. Following that, it will examine assessment issues with families of drug-using parents.

As mentioned earlier, one of the strongest and most damaging images of women drug users is that of unfit, uncaring mothers who choose drugs before their children. However some studies showed that the image of the woman drug user as an unfit mother is far from accurate an image or an assumption to make about women drug users as a group. Despite this, many social service providers, it appears, equate drug use of the illicit kind with poor parenting or mothering (Boyd, 1999; Buchanan & Corby, 2005; Campion, 1995; Maher, 1992; Smarsh Hogan *et al.*, 2006; Taylor, 1993). While recognising the importance of child protection and welfare issues and the impact that parental, particularly maternal drug use, may have on children, several social work academics and practitioners have also problematised these prevalent negative attitudes and automatic assumptions that drug use *per se* equates with poor parenting capacity and that drug use by parents places children at risk at birth or later in life (Adams, 1999; Billingham, 1999; Buchanan & Corby, 2005; Campion, 1995; Kearney, 1994). For example, Buchanan & Corby (2005: 167), while welcoming a focus on the issues of drug use and parenting in several social work texts (Harbin & Murphy, 2000; Kroll & Taylor, 2003), pointed out that

> while trying to achieve as balanced a view as possible, [these texts] have tended to see parental drug misuse as providing an ongoing risk to children's development.

Kroll & Taylor (2003: 38), however, did stress that that alcohol and drug-using mothers

> come in for particular scrutiny for a number of logical and not so logical reasons, based not only on the physical and cognitive impact of substance use on foetal development but also on stereotypes about what constitutes being a 'good' mother or mother to be.

Concerns have been expressed that the images abroad about drug users in general and women drug users particularly and their involvement in parenting may in fact influence some of those professional workers involved with making serious decisions about such women's fitness to parent and their parenting capacity (Adams, 1999; Akin & Gregoire, 1997; Billingham, 1999; Campion, 1995; Tunnard, 2002a). It has been observed that few studies look at success stories about the experiences of drug-using parents, the children of drug-using parents and interventions with these

groups and even fewer studies evaluating services from the parents' perspectives (Akin & Gregoire, 1997).

Women drug users are reported to be generally fearful about the risks of losing their children to the care of others and are also believed to be fearful of social workers. Several studies highlighted concerns about social workers' practice with regard to this group of individuals. While it has been suggested that social workers in Dublin do not hold necessarily punitive, negative or stereotypical views of drug-using parents (Butler, 1996; Clarke, 1994), other studies focusing on social workers' attitudes and parents' experiences of interactions with social workers have queried how social workers assess this group (Adams, 1999; Akin & Gregoire, 1997; Bates *et al.,* 1999; Buchanan & Corby, 2005; Buchanan & Young, 2002; Kearney, 1994; Kearney & Norman-Bruce, 1990, 1993; Norman-Bruce & Kearney, 1990). The willingness of social workers to work with drug-using parents and the attitudes expressed by these workers (Adams, 1999; Bates et *al.*, 1999; Buchanan & Corby, 2005) have also been examined while several accounts highlighted how the issue of substance use (both alcohol and illicit drug use) impacted upon the numbers of families and children coming to the attention of community care child protection teams in different locations (Forrester, 2000; Forrester & Harwin, 2004, 2006; Hayden, 2004).

Several studies of social work teams have specifically examined how they make decisions about parenting capacity (Buckley, 1998a, 2002; Scourfield, 2001, 2003). Scourfield's qualitative study of the construction of gender in the occupational culture of a social work team engaged in the child protection process explored how social workers 'constructed' women as clients, identifying how social workers perceived women as oppressed or as responsible for protection, or as making choices. Suggesting that women are sometimes 'clearly judged to have chosen to transgress expected standards of motherhood' (2001: 81), Scourfield identified how social workers define women as choosing not to put their children first – if they choose bad men, choose drink or drugs and being aggressive to social workers rather than cooperating. From the perusal to date of the literature and the ethnographies, women drug users could be argued to engage in all three activities that define them as transgressors. Many drug-using women live with a range of adversity and difficulties and may be regarded as having little hope or scope for changing their circumstances (Sterk, 1999a). Buckley's (1998) observation of a social work team in Dublin highlights how workers often appeared to 'filter out' and not engage with cases about which they believed nothing could be done.

Several studies, both among social workers and parents, have suggested that some professional workers in the child welfare and protection field may hold views that are at odds with positive working with this group (Adams, 1999; Akin & Gregore, 1997; Scourfield, 2001, 2003). Akin and Gregoire's 1997 study of parents' views on child welfare's response to addiction highlighted how attitudes and actions of workers could enhance or damage their progress. They found that the parents they interviewed identified the importance of workers' understanding of their lived

experiences of addiction, the context in which they live and their lives as parents. A study of social workers' attitudes in the UK also supported the view that negative attitudes could negatively impact on drug users and their families and were inconsistent with a family support perspective (Adams, 1999). It was noted that only a minority of the seventy five social workers surveyed held excessively punitive views that were inconsistent with such an approach. Adams reported that 99% of participating social workers believed that drug users are entitled to the same respect as everyone else, while 68% believed that many drug users are 'good enough' parents, 24% were uncertain and only 8% disagreed. On the other hand, 63% believed that parents living with children should not use drugs. 32% of respondents agreed that social workers discriminate unfairly against drug-using parents, 39% were unsure of their response while 29% disagreed. However, only 18% agreed that drug-using parents get treated as fairly as non-drug-using parents in the child protection system with 35% uncertain and 47% believing that drug users are treated less fairly. Klee (1998: 444) also highlighted the 'wholly negative picture' emerging from the characteristics that health professionals attributed to drug-using parents but did also note that their efforts to understand differed from those that would be typical of the general public. Even leaving addiction issues aside, in a study of parents' perceptions of the child protection system generally, it was highlighted that mothers wanted their workers to understand their lived experiences, be non-judgemental and avoid making assumptions (Dale, 2004).

Alongside the lack of optimism and the prevalence of assumptions about this client group, social workers' lack of confidence in their abilities to work directly with drug and other substance use issues has been identified (Adams, 1999; Billingham, 1999; Butler, 1996, 2002e; Forester & Harwin, 2006; Taylor & Kroll, 2006). This lack of confidence, knowledge or support by their agency function or managers emphasises the need for role legitimacy, role adequacy and role support for such work in the future (Billingham, 1999; Butler, 2002d; Cartwright, 1980; Shaw *et al.*, 1978). The need for addiction training for social workers is also constantly reiterated by studies (Buchanan & Corby, 2005; Forrester & Harwin, 2006; Woods, 1994).

A study commissioned by the Liverpool Area Child Protection Committee (Bates *et al.*, 1999: 9–10) found variable levels of consistency of policy and practice among professionals and agencies and much disagreement between various professionals about appropriate practice in this regard. The authors concluded that

> there is need for further research to establish the true nature and full extent of inconsistent and variable practice with drug-using parents and their children across all agencies, statutory and voluntary.

Significantly they also concluded that 'there is no evidence from this research to support the view that children of drug-using parents should automatically be registered' (p. 10). Campion (1995) also highlighted differences in and among drug-using parents, arguing that some were stable and controlled in their use, others prone to occasional crises while others were chaotic. It appears then

that the assessment process and practice is crucial to determine the parenting capacity of those parents who use drugs and the quality of care provided to children.

Assessment of Parental Capacity

As seen throughout, several authors, while acknowledging that drug users are more likely to experience parenting problems, refuted the notion that drug use *per se* automatically characterises them as bad parents (Beckett, 2003; Billingham, 1997; Buchanan & Corby, 2005; Campion, 1995; Clarke, 1994; Harbin & Murphy, 2000). Consequently, social workers need to be subtly aware of this distinction, avoid stereotypical attitudes and assumptions about such parents, enter into each assessment interaction with an open mind and above all recognise, as Kearney (1994) pointed out, that workers' personal views of parents may affect their professional work. These views cannot be allowed to impact on the assessment process. Buckley *et al.* (2006: 98) aptly noted in their assessment framework study the need to avoid generalisations while carrying out assessments. The research here highlights the importance of assessing parental capacity and risk on an individual basis.

The dilemmas facing child protection practitioners, public health and community nurses, social workers and drug agencies in the face of such concerns have led to increased attention and the issue of assessing drug-using parents has engendered interest since the late 1990s (Adams, 1999; Beckett, 2003; Billingham, 1999; Buchanan & Corby, 2005; Buchanan & Young, 2002; Buckley *et al.*, 2006; Campion, 1995; Clarke, 1994; Cleaver *et al.*, 1999; Coleman & Cassell, 1996; Forrester, 2004; Forrester & Harwin, 2004, 2006; Kroll & Taylor, 2000, 2003, 2006; Local Government Drugs Forum, 1997; Mounteney & Shapiro, 1997; Murphy & Harbin, 2000). The need for assessment guidelines has exercised practitioners, social workers, drug workers and commentators alike and both social work and addiction publications have examined the importance of guidelines for the assessment of drug-using parents in recent years. Various questions have been raised about the parenting practices of drug-using parents and the impact of parental drug use on children, which have been the focus of the earlier part of this review. Questions have also been raised about the impact of assumptions, images and public opinion on professionals' practice when involved in making decisions about an individual's appropriateness to parent, on practice issues in relation to this group and on the assessment procedures themselves.

The inconclusive and variable nature of the research reviewed in the last sections points to the importance and centrality of the assessment process where the parenting performance of a drug-using parent is under review. It appears that there is a need for assessment of each case where there may be risks. This assessment, it seems, must not be influenced by assumptions, prejudice or an automatic acceptance that the drug user status comes before that of mother/parent. The question has been posed – are they 'responsible carers, problem drug takers or both?' (Elliot & Watson, 2000: 27).

Cleaver *et al.* (1999) suggested that assessments of parenting must take into consideration the child's developmental needs, the family and environmental factors and parenting capacity of the parent or parents. Murphy & Harbin (2000) adopted this model, arguing the need for multidisciplinary and interdisciplinary approaches, and usefully adapted it to good purpose in the discussion of drug users as parents, where an assessment may be necessary. Rather than suggesting that drug use or drug addiction *per se* renders the parental role impossible, they emphasised the importance of exploring the history of parents' own parents, the parents' expectations of self as parent and the availability of the parent to the child. They suggested that two assessments need to take place – one focused on drug use and the other focused on parental capacity – and that certain clear questions need to be asked about that drug use and about the lifestyle surrounding it. Issues such as the nature of the drug, the quantity used, how, when, where, with whom and within what context it is used, how it is paid for and where it is purchased are key to the assessment of the drug use, its associated lifestyle and its potential and actual impact on the parenting capacity of the parent.

This triangulated model has been adapted in the Irish context and a new assessment framework developed to assess parenting (Buckley *et al.*, 2006). The *Framework for Assessment of Vulnerable Children and their Families* presented a general assessment tool. It provides a framework and guidelines for the both the assessment of a child's needs and the parental capacity of the parents to meet such needs with a focus on relationships, attachment, affection, health, safety and supervision, resilience and developmental milestones. It focuses on three concurrent activities in which the practitioner needs to be involved - of engaging with families, safeguarding the child's safety and collaborating and working with other professionals and disciplines. Within these activities, the five main steps include responding; protecting; devising; gathering and reflecting; and sharing, analysing and planning.

Within this new framework, there was brief mention of the impact of parental drug use on parental capacity to care for and cater for children's needs. The tool includes a focus, similar to that of Cleaver *et al.* (1999) and Murphy & Harbin (2000), on specific questions about a parent's drug use focusing on its frequency, nature and precise effect on parental behaviour – the nature of the drug use, the pattern of usage, the type of drug used and the patterns of behaviour demonstrated.

Key issues, examined earlier, such as the impact of a disorganised or chaotic lifestyle, the means by which a parent acquires money and drugs, the impact of these activities on the time and energy available to the welfare and care of their children and the provision for their basic needs, the standard of accommodation, and isolation from families and friends, were noted. In summary, the impact of drug use and its effect on the parent's ability to engage with, care for and meet their children's basic, educational, developmental and emotional needs is assessed.

At the outset of a section focusing on mental health issues, immediately following the piece on drug and alcohol-using parents, Buckley *et al.* (2006: 99) presented a caveat, remarking that

> research demonstrates a wide diversity of capability amongst parents/carers experiencing mental ill health. Some display impressive parenting, including warmth, sensitivity and understanding of their children's development and needs.

It is notable that no such caveat about the wide diversity of capability among drug-using parents was suggested despite research that has demonstrated differing ability and capacity among drug-using parents. Despite their emphasis on the importance of avoiding generalisations in the assessment, the tone of the section on drug-using parents differed to others on mental health, disability, and domestic violence.

As Skehill (1999: 175) pointed out in her conclusions of her history of social work in Ireland,

> social work, past and present, is a complex and contradictory practice, simultaneously interacting with, and being shaped by, its surrounding influences.

She continued that it is largely concerned with regulatory activities within a consensual view, that society is as given, its social conditions beyond question and that certain individuals have to be treated or fixed or maintained at a certain standard. Interestingly, Skehill expressly mentioned addiction to drugs as inappropriate parenting behaviour, which despite protestations from some academics and practitioners alike (Butler, 1996; Clarke, 1994) is possibly the way it is largely perceived by Irish social workers. This individualist perspective hides the impact of gender and class position specifically in determining many of the problems found and therefore social work could be construed as a depoliticised activity.

Despite the reportedly often negative starting points of many analyses and discussions about social work interventions with drug-using parents and their children and the negative end point suggesting a turn to American models of intervention argued recently (McKeganey *et al.,* 2002), it appears there is significant evidence to suggest the importance of proactive and supportive treatment interventions and innovative social work activities with parents and children (Berry, 1996; Byrne *et al.*, 2000; Catalano *et al.*, 1999; Dore *et al.*, 1999; Heal, 2000; Wilke *et al.*, 2005). These may then enhance family preservation and reunification or in their absence an ongoing access, contact and visiting relationship between parents and children. This necessitates an approach that is positive, strengths based and probably in many cases requires that some elements of harm reduction are incorporated into programmes (Buchanan & Corby, 2005; Keen & Alison, 2001). The needs for reflexivity and reflection (Gowdy, 1995; Schon, 1984) and additional skills with regard to social work practice in general, and social work practice with drug-using and alcohol-using parents specifically, have been identified (Forrester *et al.*, 2007). More research on social work assessment has also been recommended (Bates *et al.*, 1999; Street *et al.*, 2004). In addition to social workers' lack of knowledge and understanding about drug users, Adams (1999) also identified how social workers get sidetracked by parental drug use and drug of choice rather than staying focused on

ability to parent. The services affecting the women's lives may all impact on the parenting itself or how the parenting is perceived.

The issue of interagency work and communication between drug treatment and child protection sectors with regard to child protection has also been raised (Barlow, 2004; Bates *et al.*, 1999; Buchanan & Corby, 2005; Clarke, 1994; Forrester & Harwin, 2006; Grella *et al.*, 2006; Kearney, 1994; Keen & Alison, 2001; Kroll & Taylor, 2003; Murphy & Oulds, 2000; Rickford, 1996; Taylor & Kroll, 2004; Woods, 1994). Drug services often do not discuss parenting at assessment or during treatment (Barnard, 1999; McKeganey *et al.*, 2002; Powis *et al.*, 2000). On the other hand, within some approaches there is more attention paid to the children's needs rather than a focus on the needs of the women or mothers, reportedly a condition necessary for them to take on the motherhood role (Peterson *et al.*, 1996). The drawing up of assessment guidelines for community care teams in their assessment of drug-using parents has been recommended (Billingham, 1997; Clarke, 1994; Woods, 1994), as has been child care training for drug treatment professionals and particularly drug training for those involved in child welfare and protection work (Adams, 1999; Buchanan & Corby; Forrester & Harwin, 2006; Woods, 1994). However, where concerns have often been expressed about interagency cooperation, particularly with regard to poor communication between social work community care teams and drug treatment providers, a recent study has significantly highlighted the lack of conflict and the good cooperative relationships reporting a 'positive picture' which 'surprised' them (Forrester & Harwin, 2006: 331). The authors did, however, stress that there were often no drug or substance use 'professionals' involved with cases coming to the attention of community care. This, they believed, underlined the need for social workers to be aware of the issues, be proficient in assessment skills and possess ability and confidence to work with such a population, echoing Butler's calls (1996, 2002e) in the Irish context.

While in some cases the nature of their drug taking may affect their parenting and parenting capacity, other issues as mentioned at the outset of this section may be of relevance. The environmental risk factors are many. Many drug-using parents have themselves experienced poor parenting or negative childhood experiences (Alison, 2000; Black & Mayer, 1980; Davis, 1990; Etherington, 2006; Howe, 2005; Keen & Alison, 2001; Klee, 2002a; Nurco *et al.*, 1998; Regan *et al.*, 1987; Tyler *et al.*, 1997). Their difficulties are often much more complex than just addiction or drug dependence (Alison, 2000; Campion, 1995; Murphy, 1992; Sterk, 1999a; Suchmann & Luthar, 2000; Taylor, 1993). Poverty is a key factor (Clarke, 1994; Hogan, 1997; Hogan & Higgins, 2001a; Suchmann & Luthar, 2000; Woods, 2000), as is sexual abuse in childhood (Browne *et al.*, 1998; Etherington, 2006; McKeganey *et al.*, 2005). Lack of partner and family support, poor health and their youth on becoming parents (Kandel, 1990) may all add to the difficulties experienced.

Assessment and interventions with families where drug use is a concern are salient issues for drug treatment and social work services. Policies, treatment and even punishments for drug users are often designed and evolved based on an assumption that they are young childless men or women.

However, many drug users are parents and live with and care for their children. Despite the obvious difficulties with estimating the numbers of drug users and of children of drug users who may be affected (ACMD, 2003; Kroll & Taylor, 2003; McKeganey *et al.,* 2002; Tunnard, 2002a; Woods, 1994), it is important to have some idea about the numbers of children in order to plan interventions and supports. Generally it is believed that the invisibility of children of drug users leads to a paucity of services and supports to meet their needs (Kroll & Taylor, 2000, 2003).

It is agreed that family oriented drug treatment and childcare services for drug-using parents are necessary and that they often have very positive outcomes and benefits for parents and children concerned stabilising drug use and improving or enhancing parenting skills (Addaction Scotland, 2006; Akin & Gregoire, 1997; Berry, 1996; Bowden, 1997a; Byrne *et al.*, 2000; Carten, 1996; Catalano *et al.*, 1999; Collins *et al.*, 2003; Dore & Doris, 1997; Dore *et al.*, 1999; Downes & Murray, 2002; Forrester *et al.*, 2007; Keen & Alison, 2001; Keen *et al.*, 2000; McKeganey *et al.*, 2002; Plasse, 1995; Powis *et al.*, 2000; Schuler *et al.*, 2002; Shulman *et al.*, 2000). Treatment programmes that address family issues, allow for peer support and contact among pregnant and parenting women, and residential services that accommodate their children are likely to retain women and give rise to benefits for the women and children (Grella *et al.*, 2000; Hughes *et al.*, 1995; Rice, 1994). It has been argued that the creation of 'safe havens' for the children of drug-using parents is essential (McKeganey *et al.*, 2002) while in relation to support services for children so affected it has been suggested that '[t]hey should be all all over the place' (Byrne *et al.*, 2000).

Concerns arise about the overwhelming negative accounts of drug users' involvement in parenting. These may ultimately affect workers' willingness to engage with such individuals and may impact on assessments and undermine supportive interventions. Buchanan & Corby (2005: 176) lamented the fact that many assessment frameworks are simply too general for work with families where drug use is an issue and that some useful frameworks and guidelines have had little impact to date on practice. It appears on the basis of much of the literature reviewed that treatment optimism, that is, a belief that interventions may be effective, a non-moralistic perspective and rejection of stereotypes of drug-using mothers/parents are crucially important characteristics or skills for workers involved with this group. Finally, it is suggested that an understanding of the social context, in which drug–using parents live their lives, is vital.

In summary, this section has reviewed the literature concerned with the assessment of parenting capacity of drug–using parents and the attitudes and practices of those who assess them. There appears to be in both the drugs and childcare literature an assumption that problem drug use impedes parenting and that reduction of drug use can render parents better at parenting and providing a nurturing environment. Some commentators suggest that parental or maternal drug use and addiction are unequivocally linked with parenting deficits. There are those who assert that a drug-using woman cannot be a good (or even adequate) mother. The overwhelmingly negative picture of drug-using parents emerging and the impact of their drug use on their children is a

feature of much of the work reviewed. However the need for supportive, proactive and family strengthening programmes, thus aiding family preservation, has also been advocated by several studies.

Conclusion

The aim of this chapter was to review the main issues in the literature focusing on women's drug use, women drug users' pregnancies and mothering careers, parenting practices and the impact of parental, mostly maternal, drug use on the children of drug-using parents. It also aimed to review the recently increasing literature focusing on the interactions between drug-using mothers and their assessors, social workers in the assessment process. It has attempted to approach the research with an 'enquiring mind' (Tunnard, 2002a).

The four broad thematic areas reviewed then responded to a number of questions. What do we know about women drug users? What do we know about women drug users' experience of motherhood? What do we know about drug-using parents? What do we know about the impact of parental drug use on children?' What do we know about social workers' involvement in assessments of parental capacity of drug-using mothers?' The four sections are salient to the research questions posed with regard to women drug users' own accounts of their experiences of motherhood, the professional workers' perceptions of their experience as mothers and their capacity as parents, and the interactions between these two groupings, as raised initially in Chapter One and explored further in the next chapter.

As the preceding sections demonstrate, drug use and parenting simultaneously often pose considerable difficulties to be overcome by drug-using parents (mainly mothers) and considerable uncertainties and lack of routine to be endured by children and extended families. The challenges to drug treatment and social work services are also very great. Research on women drug users has been variously described as 'neither fair nor exceedingly accurate or objective' or 'spotty' (Rosenbaum, 1981a: 6), based on 'erroneous assumptions' (Ettorre, 1992: 6), or outdated (Taylor, 1993: 4). Given that a gender sensitive focus on women and drug use is relatively scarce (Ettorre, 1992, 2004; Raine, 2001) and there exists to date only a 'fledgling discourse ... about drug-using women and parenting' (Barker & Hunt, 2004: 348), it appears timely that drug-involved motherhood merits attention in this study.

Generally little is known about the lives of women drug users, women drug users as parents and the children of drug-using parents in Ireland. Other than estimates, the numbers of children born to or cared for by those who are in receipt of drug treatment are not currently collated or available. In Ireland, few treatment services have been established to meet the needs of women or mothers.

In recent years, studies of children of drug-using parents have become more common, thereby increasing the visibility of this issue. The lifestyle associated with illicit drug use has been identified

as one that potentially may cause harm to children of drug-using parents. Despite such obstacles and barriers many parents, mostly women, manage to parent, successfully maintaining their careers in parenting with or without supports and interventions from services. A review of the literature reveals that while an overwhelmingly negative picture exists, there is in fact inconclusive, contradictory and variable evidence about the impact of parental drug use or exposure to parental drug use *per se* on the lives of children. In addition, as Collins *et al.* (2003: 238) pointed out, research on parental drug use has largely focused on the effects and impact on children, while little research has focused on the parents themselves.

While issues of child protection, welfare, family welfare and the welfare of mothers are crucial subjects in their own right, the impact of motherhood on the lives of women drug users needs further study in order to inform services that might improve their lives, and those of their children. With the exception of a few compelling texts, a vacuum exists in the literature with regard to studies of women drug users' lived experience of mothering and motherhood. The need to pursue knowledge of the everyday life experiences of women drug users as mothers, the management of their two careers and the outcomes in the long-term for drug-using mothers and their children generally, but particularly in the Irish context, is crucial. Such knowledge can only enhance the practice of treatment providers and social work personnel ultimately.

The review suggests two gaps. One concerns the paucity of studies focusing on the impact of children and the motherhood role on women drug users. In addition, few studies explore their mundane existence as mothers using drugs, the focus of this thesis. The literature review, focusing as it does on the experiences of women in interaction with those who assess their parenting capacity, also suggests the need to focus on women's drug use and motherhood experiences as a outcome of a process of interaction taking place between the women and professional service providers. The review also identifies the tenuousness of the drug use and motherhood collision, a phenomenon that only recently has garnered attention from reseachers and commentators.

This study, which views women's motherhood experiences as shaped by their interactions with their children, partners, families, communities and the professional service providers, such as drug treatment professionals and social workers, attempts to go some way to filling these gaps and addressing this drug use/motherhood collision as its central theme.

The conduct and approaches to research among women, mothers, parents and professional workers reviewed here have also informed the next chapter, which examines the methodology and theoretical frameworks underlying and integrating this study. It identifies the methods adopted in order to generate the data needed to respond to the major research questions posed.

CHAPTER THREE

MOTHERHOOD AND DRUG USE EXPLORED: METHODOLOGICAL ISSUES

> . . . for where you stand will doubtless help to determine not only what you will research but also how you will research it.
>
> (Punch, 1998: 179)

This thesis presents the findings of a qualitative research endeavour, exploring women drug users' experiences of motherhood, and recounts the stories of the women, workers and others who participated. However it also involves another story - that of the actual process, the doing of the research. This chapter outlines how the women's experiences of motherhood and parenting have been explored, describing the conduct of the research process and outlining the theoretical and methodological approach underlying the data collection and analysis. It details the research methods and strategies adopted to achieve the stated study aims, highlighting ethical issues, gaining access, the setting, the sample and the interview process.

This account focuses particularly on the author's experience. In describing the process and identifying challenges encountered, the constant struggle with issues such as 'objectivity', 'truthful' accounts and exploring how insider status impacted upon the ability to gather the data in a manner that approached participatory ideals, it is hoped to make this account relevant to the project at hand. In the following discussion, I wish to avoid what has been termed as 'methodolatry', 'a combination of *method* and *idolatry*, to describe a preoccupation with selecting and defending methods to the exclusion of the actual substance of the story being told' (Janesick, 1998: 48). The discussion of the methodology and methods highlights epistemological and ontological issues involved.

In describing the research process, it will appear that there were five discrete, neat and tidy moments or stages through which the research moved – proposal, design, data gathering, analysis, write up. However, as others (Hammersley & Atkinson, 1995; Maher, 1997; Mason, 2002; Miles & Huberman, 1994) have pointed out, in practice these stages are often not easily delineated or separated. Firstly, the research project, its aims and key research questions are described. An exploration of the main theoretical, methodological and paradigmatic influences follows. The sampling and recruitment processes and the groups participating are then introduced, as are the research methods – interviews, focus groups and participant observation – and analytical approaches employed. Challenges, such as access, negotiation with gatekeepers, ethical issues and being perceived as being on the side of the fallen angels, are then explored and reflections on some of the dilemmas with regard to 'truth' and 'validity' encountered during this project are also offered.

The Research

Drawing on a qualitative and interpretive perspective, employing research methods such as in-depth interviewing, semi-structured interviewing, focus groups and participant observation and informed by a feminist perspective, this study aims to elicit the views, opinions and experiences of motherhood and parenting from women affected by illicit drug use. It also presents the findings of interviews with professional workers, counsellors, social workers, nurses, doctors and others, who impact on their lives. The data presented in this thesis were gathered in Dublin over a three and half year fieldwork period from January 1999 – June 2002. Member checking continued during much of the analysis and writing up period. In total 205 women and 100 workers were encountered. In addition, eight teenage and adult children of drug-using mothers, several partners and family members were also consulted. One hundred interviews, 14 focus groups and lengthy periods of observation, during which conversations and interactions with women drug users took place, were conducted. A participatory and emancipatory 'partnership' approach was adopted and participation and consultation with participants occurred at every stage of the process - proposal, design, data collection, analysis and presentation. Several research consultants were invaluable and evaluation of the research experience at the time of interview and at later meetings was also an intrinsic part of this process, as was member checking following transcription and during analysis and write up.

To restate, the aims of this study at the outset were to document women drug users' experiences of motherhood and parenting and their interaction with drug treatment and social work systems. It also aimed to document professional workers' perceptions of women drug users' experience of motherhood and competency with regard to parenting and explore the dilemmas encountered by professional workers. It was also aimed to keep central to the account the women's voices, adding them to the voices of the 'experts', the commentators and the professionals working in the field.

Research Questions

The initial proposal and design then were impacted upon by my practice experience and some selected literature and texts. As I had worked for a lengthy period in a frontline harm reduction and low threshold[34] drop-in centre in Dublin's inner-city, my (former) practitioner status must be acknowledged (Darlington & Scott, 2002; Fook, 1996a, 1996b; Schon, 1983), amounting as it does to a certain privileged and 'insider' status with all groups of participants. The development and refinement of the design, such as the identification of research questions, were impacted upon by the extensive perusal and exploration of the literature throughout the fieldwork period and indeed by the data gathering and analysis process itself, which in the tradition of an inductive grounded theory perspective were inextricably related.

[34] Low threshold' is the term used to describe agencies that are accessible and user-friendly agencies for drug users – often described as 'street agencies', contact centres, drop-in centres or needle exchanges. Generally these agencies will work with drug users whether or not they have made a commitment to becoming drug free. A harm reduction approach underlies this perspective.

The initial research questions, presented in Chapter One, were concerned with, firstly, the women's accounts of motherhood and their views of service provision; secondly, the professional workers' accounts of the women's experiences as mothers and their views about the women drug users' competency as parents; thirdly, the interaction between these two groups and fourthly, the tensions and contradictions if any inherent in these accounts.[35]

However, as a result of immersion in the literature, some time in the field talking with and meeting women directly affected by the issues and meeting professional workers, the focus became sharper. Prompted by a life history type question, used in many studies with women drug users (Etherington, 2006; Murphy & Rosenbaum, 1999; Rosenbaum, 1981a; Sterk, 1999a), posed at the outset of conversation and interviews, the women stressed the symbolic relevance of motherhood in their lives – experiences of having been mothered, becoming mothers, being mothers, performing motherhood, being challenged as unfit mothers and losing motherhood.

Consequently the study shifted from solely looking at the doing, practice or process of everyday mothering or parenting to also exploring in a more fundamental manner the meaning of motherhood in their lives. While the original research questions still applied, others focusing on meanings and experiences and sense-making were added. These research questions included:

- How does motherhood feature in the lives of women drug users in Dublin?
- How do they define the mothering role?
- How do their children impact upon their lives?
- How does motherhood/mothering impact upon their drug use?
- How does drug use impact upon their children?
- How does drug use impact upon their mothering/motherhood?
- How do women manage both drug use and motherhood?
- How do they manage the stigma, the spoiled identity associated with being a drug-using woman and a drug-using mother?
- How do they deal with and experience services and families?

Quality rather than Quantity? – Methodological Perspectives

> Qualitative data, with their emphasis on people's "lived experience", are fundamentally well suited for locating the *meanings* people place on the events, processes and structures of their lives: their "perceptions, assumptions, prejudgements, presuppositions" (van Manen, 1977) and for connecting these meanings to the *social world* around them.
>
> (Miles & Huberman, 1994:10)

[35] The first research question about the women's accounts of their everyday experiences of motherhood, led the women to discuss a range of issues, how they mothered while using drugs, while receiving treatment on methadone maintenance programmes, while drug free or in recovery; how they interacted with their children, partners, parents, siblings, communities and professional workers. The second question, regarding the professional workers' accounts of the women's experiences, led to an exploration of the workers' views and accounts of the women's experiences and the interaction between the two groups. This further addressed the third and fourth research questions about the interactions between the two and the dilemmas encountered by professional workers. It was possible to view different discourses at play, which lead to some discussion and conclusions with regard to interactions between the two groups.

In an effort to access both the women's and professional workers' accounts of drug use and motherhood, the research was then designed in order to identify strategies and approaches best accommodating the generation of such data capable of responding to these research questions. Much about meanings, feelings, thoughts, perceptions, memories and understandings was central to the study. In order to understand women's experiences and the meaning they attached to them, their 'careers' and pathways through life (Goffman, 1961, 1963), an interpretation of the participants' experience (Guba & Lincoln, 1998) was crucial. Therefore, it appeared that qualitative inductive research within a feminist and interpretivist framework, aspiring to participatory ideals with a particular emphasis on reflexivity, was the most appropriate strategy.

Several authors writing recently on the qualitative/quantitative divide (Darlington & Scott, 2002; Martin & Stenner, 2004; Mason, 2002; Oakley, 1998, 2000) have argued that an automatic rejection of one approach or the other as being inferior, unfeminist, or merely positivistic is unhelpful and reductionist. Indeed more than 30 years ago, Oakley (1974) argued that women were invisible or underrepresented in sociological studies and later strongly advocated the importance of women interviewing women (1981). She has latterly revisited this qualitative and quantitative divide (Oakley 1998, 2000) and has argued for abandoning the language of 'qualitative' and 'quantitative' altogether. While the debate about 'competing paradigms' has permeated much of the discussion about feminist, sociological and other research during the 1980s and 1990s (Denzin & Lincoln, 1994, 1998, 2005; Guba & Lincoln, 1998: 195; Oakley, 1974, 1981), it has also led to Janesick's (1998) claim about researchers' defensive justification for adopting one perspective or another.

Having said that, it is important to point out that in an attempt to examine the contested and little researched experience of women drug users as mothers, it was necessary to move away from a notion of simply gathering statistical details about the women's lives. The focus on such an area necessitated that the study be exploratory, neither seeking to prove nor disprove any theory or hypothesis. Rather it was intended to access the accounts of women's and workers' experiences, identifying emerging concepts and theories. This study has adopted an overall qualitative framework. This approach was chosen rather than a quantitative, deductive, positivist perspective. In the context of this project's exploratory point of departure, stated aims, research questions and design, a qualitative approach adopting research strategies and mixed methods such as observation, in-depth interviews and focus groups, was most appropriate for the purpose. Accessing participants' views, descriptions, experiences, sense of those experiences, meanings and perceptions (Mason, 2002) as a central aim necessitated offering people the opportunity to describe at length and construct their experience.

Reluctant to reduce qualitative research to a set of prescribed guidelines, Mason (2002: 3-4) nonetheless identified it as grounded in an interpretivist philosophical perspective concerned with how the social world is understood and explained, based on data generating approaches which are

versatile, flexible and responsive to the social context in which they are produced. She also asserted that this approach should be based on methods of analysis, which encompass an understanding of complexity and again, importantly, an appreciation of context. Other commentators identified similar traits (Denzin & Lincoln, 1994, 1998, 2005; Miles & Huberman, 1994; Miller & Dingwall, 1997). A significant number of researchers pointed to the creative nature of the qualitative research endeavour and interpretative project, referring to research, interviewing or analysis as an art (Denzin & Lincoln, 2005b; Rubin & Rubin, 2005; Trinder, 1996). Miles & Huberman (1994: 1) claimed that qualitative data are 'sexy ... a source of well grounded, rich descriptions and explanations of processes in identifiable local contexts'. In addition, it has been suggested that it is the duty of qualitative researchers to be rigorous, meet challenges and be reflexive in the generation and analysis of these data (Barnard, 2005a).

The study used grounded theory perspectives and techniques (Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998) to gather and analyse data generated with a range of participants and using several research methods. This approach informed many other studies with drug users, particularly drug-using women (Goode, 1999; Kearney, 1993; Kearney *et al.*, 1994; Kovaleskey, 1997; Murphy 1992; Murphy & Rosenbaum 1999; Rosenbaum, 1981a). Throughout the fieldwork period, reflexive strategies were employed and the analysis was largely guided by the principles and practices of a grounded theory analytical approach. Theoretical sampling, theoretical questioning, constant comparison, coding and memo writing were central to the ongoing analysis while generating data in an effort to ground the theory in the data. These strategies and activities were employed in order to achieve 'theory building'. It was hoped that a grounded theory might emerge from the data generated about the lived experiences of the women as mothers (Glaser & Strauss, 1967, 1970).

Furthermore, other theoretical positions or traditions and interpretive frameworks have influenced or shaped the focus and thinking since the inception of this research project. These include feminist theory, resistance frameworks, symbolic interactionist perspectives and other theories of social action, ethnographic tradition and structuralist perspectives. Many of these, both structural and processual focused perspectives, have influenced ethnographic and qualitative research among drug users (Agar, 1973; Becker, 1963; Bourgois, 1995; Faupel, 1991; Friedman & Alicea, 2001; Maher, 1997; Mayock, 2000, 2003; Neale, 2002; Pearson, 1987; Preble & Casey, 1969; Rosenbaum, 1981a; Sargent, 1992; Sterk, 1999a; Taylor, 1993; Waldorf, 1973; Waldorf *et al.*, 1991; Waterson, 1993, 1999). The importance of avoiding an asocial, decontextualised or gender blind analysis of the women's experience (Ettorre, 1992; Perry, 1979; Raine, 2001) was also acknowledged. Alongside these influences, from an early stage in the design process when consulting with potential participants, the range of discourses used by participants in order to describe, illustrate, make sense and comprehend their experiences of the issue of drug use and motherhood became evident, as noted in other studies (Denzin, 1987; Friedman & Alicea, 2001).

Secondary sources offering statistical data about the experiences have been used at points in order to buttress many of the qualitative findings of this study. The data, while qualitative, illustrative and descriptive, have also been analysed in such a manner that frequency of occurrence of recurrent and salient themes across the sample have been measured throughout.

Ethnographic principles have informed this research throughout. I attempted to make contact with women and workers in natural settings, to observe their activities and to access their accounts and the meanings they attached to their lives and experiences. Much time was spent in an observation role with people in their own work, home and street settings at various places in Dublin. In an effort to avoid superficial observations or a 'hit and run' data-gathering process dependent solely on interview bemoaned by some (Atkinson & Hammersley, 1998; Oakley, 2002; Scheper-Hughes, 2000; Silverman, 1997), I maintained a field presence for a longer period than many others describing themselves as ethnographers, who quickly recruited through gatekeepers, interviewed their participants on one or two occasions and left the field. For example, while some researchers spent lengthy periods in the field (Maher, 1997; Taylor, 1993) carrying out their interviews in the final months of their fieldwork, others have based their entire ethnographic studies on in-depth qualitative interviews rather than observation.

Research endeavours often become focused on the researcher and participant becoming involved in a sense making and interactive process. I purposely adopted a particular stance or position with regard to those interviewed, viewing them as participants, rather than the 'researched', the objects of research or researched subjects. This reflects a feminist preoccupation with power, inequalities between the researcher and the research participant and attempting to narrow the gap between those researched and those conducting the research endeavour (Fonow & Cook, 1991; Lentin, 1993; Mies, 1983, 1991; Oakley, 1981; Stanley & Wise, 1993). A concern with participatory ideals, (Gatenby & Humphries, 2000; Lynch, 1999, 2000; Okeley, 1994; Reason, 1998), also led to engaging in a sense-making experience, asking for feedback and consulting with participants at every stage of the process. Issues with regard to power, the positions, both ontological and epistemological, of the researcher, and the emancipatory or participatory approach employed are central to the choices made with regard to methodology and method.

It has been suggested that 'traditionalists tended to eschew "politics", to avoid "total immersion", and to be wary of "going native", all of which, in contrast, are elements of feminist methods' (Punch, 1998: 162). Feminism, with its emphasis on questioning power relationships, necessitates that researchers set out to explore phenomena with an ethical and political conviction about improving the situation of those involved in the research, should their situation need improving (Fonow & Cook, 1991). It has been argued compellingly that a feminist approach is most suited to research of a sensitive nature. While motherhood is often a sensitive area of inquiry, an exploratory study of women drug users' experiences of motherhood could indeed be described as a doubly sensitive issue. As the previous chapter demonstrated, the motherhood/drug use axis has been most

problematic for women drug users and exactly the point at which many moral judgements are made about good and bad women and mothers. This highlights the importance of inclusiveness, incorporating and making central the women's voices, and even more so the making central of the voices of women often defined as 'problematic', 'deviant' or 'beyond the pale'.

Keeping gender central to the analysis was also crucial. The question 'Is it different for girls?' was raised when discussing each and every issue. While women interviewing women (Oakley, 1981) or women working with women may appear to level the playing field, promoting equality and eliminating the gap between the worker/researcher and the client/participant, it may be simply that – an appearance or impression. As a middle-class woman worker or researcher, one must be aware of the major power differentials between and among women. Researchers and workers often find a position or location as individuals, moral judges, and in a sense represent a 'view from above' (Mies, 1991). Other researchers have also engaged with these issues, some believing that there was automatically a smaller power differential precisely because they were women interviewing women. Some believed that women accepted their presence as interviewers or observers more readily because of their gender or that the women benefited in a therapeutic sense from participation in research projects (Finch, 1984; Murphy & Rosenbaum, 1999; Rosenbaum, 1981a; Taylor, 1993: 23). Others were, however, more reflective and reflexive about the gaps between their own and their participants' lives (Maher, 1997; Mies, 1991; Oakley, 1981).

Coming from a practitioner background also influenced my research conduct and demeanour, in particular with regard to reflexivity, reflection and ethical issues (Darlington & Scott, 2002; Fook, 1997b; Schon, 1983), some of which will be reviewed later.

Sampling and recruitment

More than 300 participants took part in this study. Non-random sampling strategies, purposive, convenience or selective and theoretical, were employed. A concern with diversity rather than representativeness was central to the project. Several parts of Dublin's inner-city, both north and south of the River Liffey, known for high levels of drug use and with a presence of statutory, non-governmental and community-based agencies, were chosen as the study locale. Twenty-three of the 26 women interviewed currently resided in these areas while three were either involved with services or were contacted there. Most of the 179 women focus group participants and fieldwork contacts were also resident in the areas, but at the very least all were contacted there. These areas have been characterised as impacted upon by poverty, deprivation and a range of multi-layered difficulties (Ana Liffey Drug Project Reports, 1990, 1991, 1992, 1993, 1994, 1995, 1996; Butler, 1991, 2002a; Coveney *et al.*, 1999; Cullen, 1994; Dean *et al.*, 1983; *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*, 1996; Mayock, 2000, 2003; Murphy-Lawless, 2002). Since 1990 successive studies of the extent of treated drug use in the Greater Dublin area, reviewed in the introductory chapter, identified these areas as affected by the drug use

issue, with often as many as a quarter of all those receiving treatment in Dublin or the Republic of Ireland hailing from those areas.

This study endeavours to explore this issue with women drug users in general, not necessarily focusing on those already in contact with services or experiencing difficulties as mothers. As pointed out earlier, it did not draw its respondents or data from the records of courts, from child protection registers or even from drug treatment agencies (Baker & Carson, 1999; Famularo *et al.*, 1992; Forrester, 2000; Forrester & Harwin, 2006; Hayden, 2004), although some of the women interviewed may indeed have been in contact with such agencies. The women participants were recruited variously through participant observation, snowballing/chain referral strategies and, in several cases, through one drug project. Recognising the heterogeneity of women drug users and through a process of theoretical sampling, different women at various stages of their lives, their drug-using careers and their parenting careers from a variety of different socio-economic and educational backgrounds were engaged.

Drug users are generally regarded as a 'hard-to reach population', drug-using mothers even more so (Goode, 2000; Hogan, 1997; Kearney & Taylor, 2005). Rather than being a hindrance, insider status and association with many drug-using women and professional workers provided significant opportunities in terms of entry to the field and introduction to a vast number of women and several professional workers unknown at the outset. In an attempt, naïve perhaps, to distance oneself from conveniently selecting participants on the basis of previous and insider knowledge, initially it was intended to recruit through identified agencies in the study locale, all of which were in principle willing to assist. However difficulties emerged with one agency acting as a gatekeeper, a phenomenon identified in another study of substance-using mothers (Goode, 2000). Alongside this setback, further reflection on sampling demonstrated that the recruitment of those in contact with treatment agencies only was in fact imposing limits on the heterogeneity and diversity of the sample (Boyd, 1999; Ettorre, 1992; Taylor, 1993). As a result, a number of sampling strategies were employed, recruitment through participant observation, willing agencies[36] and snowball sampling or chain referral (Waldorf *et al.*, 1991), where respondents assisted in introducing the researcher to other respondents who then suggested others who might be willing to participate and often made introductions.

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[36] One agency, with which I had prior contact, allowed me to spend weeks with the programme and offered me facilities for interviewing and meeting with the women attending. As the research continued over a number of years, several agencies offered assistance. One worker attempted to organise interviews with women currently in prison. This eventually proved impossible for a number of reasons. I was somewhat relieved as I was concerned that raising these particular issues with women currently in prison and separated from children might prove too painful. Other researchers (Enos, 2001; McCann James, 2004; Malloch, 1999, 2000a, 2000b; Watterson, 1996) had spent longer periods in prison environments carrying out participant observation and voluntary work before and after interviewing.

Consequently, a heterogeneous sample with regard to age, motherhood experiences, stages of motherhood and drug histories was recruited. The sample was not solely concentrated in drug treatment programmes, residential programmes or methadone clinics. In addition, not all participants were using street drugs. I also spent a lot of time 'hanging around' agencies and street locations near agencies and 'the scene' and women sometimes approached me when they heard about the project. Many women, whose children were in the care of others, approached me and wanted to participate and be involved. As a result many different accounts emerged adding to the richness of the data and the roundedness of the trajectory. If the sample had only included those who were successful in maintaining custody and their motherhood role, an important aspect of drug-using mothers' experience would have been omitted.

Adopting the aforementioned grounded theory perspective permitted theoretical sampling and constant comparison, while the exploratory, feminist and participatory frameworks necessitated constant reflection and reflexivity within the process. As mentioned earlier, I initially set out to recruit only those women with children in their care during the research period and on reflection that changed. Similarly, over time I also decided to include several other participants such as the adult children of drug users and family members, such as mothers or partners. This assembly of theoretical and purposive sampling strategies permitted versatility and reflexivity, necessitating ongoing reflection on the data generation process and changing strategies where necessary in response to the women's or other participants' experiences. Consequently, the originally envisaged limited sampling strategy was altered to enhance the inclusive nature of the project.

Participants – the sample

At the outset, two groups of potential participants were identified. However the reflexive and reflective nature of the research process lead to changes in strategies at different moments. Sampling issues were revisited throughout. Therefore three groups of informants took part in interviews, focus groups and interviews during participant observation, presenting a number of different views. They offered both emic and etic, that is insider and outsider, viewpoints about the women's lives as drug-using mothers.

- Women with a history of drug use, the majority of whom were mothers
- Professional workers in the drug treatment, social work, medical, nursing and community work fields
- Family members – partners, mothers, sisters and several teenage and adult children of women drug users.

It was not originally envisaged that the latter group would be potential participants. Yet, as the women's stories of motherhood unfolded, this group emerged as key actors in the accounts and as a result it was useful to interview informally a small number of people in this situation. The voices of the women are those which are central and interviews and observation gave rise to much 'thick

description' (Geertz, 1973) and later 'theory building' about their experiences (Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). However, the data gathered from professional workers also provided a springboard to society's and service provider's perspectives on the women. Every individual requested to participate agreed to do so and many others volunteered their participation.

Women drug users

205 women drug users at varying stages in their drug-using and parenting careers with an age range of 16-48 years participated.[37] 193 mothers, 9 women who were not yet mothers and three women currently pregnant for the first time offered their insights, ideas, experiences, feelings, fears and visions of motherhood. The nine women who were not yet involved in mothering, talked about their missed opportunities to date to become mothers and their future aspirations for motherhood. Of the women encountered, 135 participated in informal interviews and discussions, while 26 women were interviewed on two or three occasions throughout the final year of fieldwork and 52 participated in focus groups (eight of whom also were interviewed).

While many women participated, it should be noted that this sample is not strictly representative of the population of women drug users from a statistical point of view. Although some estimates of the numbers of opiate users in Dublin and in Ireland exist (Comiskey, 1998; Kelly *et al.*, 2003), reliable and accurate estimates of the size of the opiate-using population remain elusive due to the illegal and hidden nature of drug use. Other studies of women drug users have noted this phenomenon (Raine, 2001; Taylor, 1993). However, the numbers of women involved in this project are considerable. Almost one third of approximately 7,000 individuals (as many as 2,333) in treatment in the Republic of Ireland are women. An estimate of opiate users in Dublin in 1996 suggested that 13,461 individuals used drugs, 3,117 (a little more than 23%) of whom were women (Comiskey, 1998; Comiskey & Barry, 2001). Later estimates suggested that of 12,456 individuals using opiates in Dublin in 2001, 4,178 (33.5%) were women (Kelly *et al.*, 2003). In this study the 205 participants, although 20 were at the time drug free, may constitute almost 5% of the female opiate-using and treated population in Dublin. I also maintain that the 70 women who participated in in-depth interviews and focus groups are largely representative of the 205 women encountered during fieldwork.

Initially, as my aim was to explore women's day-to-day experiences of mothering, I planned to interview women currently involved in the day-to-day parenting of their children. After a short period in the field, it became evident that many women put themselves forward for consultation and interview eager to speak of their experiences of mothering or living without the mothering role. The initial approach was altered to adequately reflect the diversity and heterogeneity of the women's backgrounds, lives and experiences.

[37] Detailed profiles of the women appear in Appendices II, III and IV.

Women therefore were not excluded because they were not caring for their children on a day-to-day basis. Of the 26 interviewees, 13 were women with all their children in their care at the moment of interview. Five women had some of their children in their care, while all of the children of seven women were in the care of others. One woman's children were all adult. For the purpose of the study, it was invaluable to involve women at various ages, at differing stages of their drug-using, drug treatment and parenting careers and with different perspectives in order to highlight the diverse nature of experiences and accounts. This presented the opportunity to explore these issues from a number of perspectives.

Professional Workers

At the outset, it was planned to interview 20 professional workers. However through snowball and theoretical sampling, twice the numbers of interviews originally envisaged were conducted between January 1999 and February 2002. The doubling of numbers meant that a wide range of actors from a practice and policy point of view was interviewed and as a result this has contributed to diversity and difference. A total of 100 workers participated. Forty workers were interviewed.[38] Fifty-two workers participated in focus groups (seven of whom were also interviewed) while a further 15 participated in informal interviews and discussions. Those selected for interviews were considered to be key practitioners and were a group defined by their knowledge and experience. Several had worked for lengthy periods, ranging from three to almost 30 years, in a series of positions in the drugs, medical, nursing, social work and community work fields and had responded cumulatively over their work histories to thousands of women drug users affected by these issues. Of those interviewed, 29 were women and 11 men. Thirteen workers described themselves as addiction counsellors, drugs workers or community drug workers, working in a variety of drug services and projects; 14 were social workers, working in drug treatment, child protection social work teams, probation and welfare and maternity hospital contexts; four were medical consultants, whose specialisms were psychiatry and public health; two were refuge workers; one was a teacher; five were nurses, working in drug treatment, antenatal care, HIV care and outreach and one was a child care worker. In total, 40 professional workers were interviewed.

Family members and children

Introducing other informants came about as a result of both theoretical sampling and opportunity. Bringing children into the picture was a response to the exhortations and challenge of a community care social worker, who suggested that including children might add a '*different*' view. It was decided to include a number of brief and informal consultations with several young adult children of the women and with mothers and male partners of some of the women. These discussions were brief but telling. In total eight young people participated as did ten family members, mostly mothers, and ten male partners.

[38] See Appendix V

Data collection – Methods and Process

In-depth and semi-structured interviews, focus groups, observation and member checking were the methods used to collect and verify data during the fieldwork period and beyond, thereby ensuring safeguards with regard to rigour. In addition there were several data sources as identified above.

Interviews

One hundred interviews were carried out, 40 semi-structured interviews with individual workers (January 1999 – February 2002) and 60 in-depth interviews with 26 women drug users (June 2001 – June 2002). Two preliminary pilot interviews were carried out with workers at the end of 1998 and two pilot interviews were conducted with women in April 2001. In advance of all interviews, an explanation of the aims and objectives of the study was outlined sometimes in an introductory conversation, by phone or in some cases by letter. Participants had time to think about their participation between being invited to participate and the actual interview. The purpose of the interview was again explained in detail at the outset. Prior to interview, the issue of informed consent was addressed and written consent obtained.

While topic guides were developed consisting of a list of areas of interest and a large number of sample open-ended questions for interviews with the women and the workers, these were not referred to in any formal way during interviews. They were used largely as *aides-memoire* for the interviewer. The respondents' views, interests and concerns guided the interviews following the life history type question asked at the outset. Each interview was different in duration, the number of questions asked, the order of topics covered. They all nevertheless covered the same basic themes as laid out in the topic guides. At the close of all the interviews, an evaluation of the interview process took place.

A range of topics were explored in the interview and focus group contexts. With the women participants these included:

- Their life histories
- Their day-to-day experiences as drug users
- Their day-to-day experiences as mothers;
- The perceived differences between their and men's experiences as drug users and as drug-using parents
- Their experiences of services;
- The social context and environment in which they lived;
- The dilemmas arising from their interactions with workers.

The interviews and focus groups with professional workers focused on the following:

- Their experiences working with women drug users generally and as mothers;
- The differences in men and women's experiences as drug users and as drug-using parents
- The women's day-to-day experiences;

Their parenting capacity and experiences;

Their perceptions of women's experiences of services;

The social context and environment in which the women lived;

The dilemmas experienced by workers.

Interviews were carried out in a number of locations including the researcher's office, peoples' homes, drug agencies, social work agencies, researcher's home, and the street. The interviews varied in length from 90 minutes to four hours. All interviews were audio-recorded using a tape recorder or a mini-disc recorder. These tapes were listened to immediately after interview, content noted, and memos written and pondered upon. They were later transcribed verbatim, read and reread.

All directly identifying information was removed from transcripts and throughout pseudonyms or numbers were adopted to protect confidentiality. The women have been given pseudonyms, some of which they chose themselves.[39] Originally the women were also allocated an identifying number along with the pseudonym. However so many described their experiences of *'just being a number'*, that it was decided to remove these and leave them with names. Their 68 children have also been given pseudonyms.[40] The workers were described throughout by professional background and, since in all except two cases there was more than one worker in the category,[41] numbers from 01 – 40 were allocated in order to distinguish between workers.

Verbatim comments have been altered slightly as the spoken Dublin dialect may not always be understandable to all readers. All personal details where used in the text, accounts of experiences in mothering and drug use are as recounted and quotations with some small editions are accurate representations of the participants' words and accounts. In the findings chapters, the words of women or professional workers appear throughout in italics. Some exceptional personal details, which were evidently identifiable, have simply not been mentioned in an attempt to ensure confidentiality.

Focus Groups

Fourteen focus groups were conducted during the fieldwork period, eight with workers (52 participants in total) and six with women (52 participants) directly affected. They took place in a variety of locations and for varying lengths of time, ranging from 50 minutes to one and a half

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[39] The 26 women were renamed Alison, Amy, Andrea, Arlene, Avril, Brenda, Darina, Elaine, Ellen, Emma, Ethna, Frances, Helen, Janet, Jenny, Katherine, Laura, Liz, Maeve, Marina, Rachel, Sandra, Sharon, Sheila, Susie, Wendy. The 44 women in focus groups and the 135 women in fieldwork were also given pseudonyms as can be seen in Appendix III.

[40] See Appendix VI

[41] See Appendix V - Thirteen addiction counsellors/drugs workers/community drug workers (W 02; W 04; W 05; W 06; W 08; W 11; W 16; W 18; W 19; W 20; W 34; W 36; W 38) fourteen social workers (W 01; W 03; W 09; W 13; W 15; W 17; W 21; W 23; W 26; W 31; W 32; W 37; W 39; W 40); four doctors (W 12; W 28; W 29; W 30); two refuge workers (W 14; W 27); one teacher (W 22); five nurses (W 07; W 10; W 24; W 33; W 35), one child care worker (W 25).

hours. They were later transcribed verbatim and all directly identifying information was removed from transcripts.

Observation

Initially, it was planned to conduct interviews and focus groups. However, on reflection, observation was included and many hours, days and nights, were spent in gathering data in this way. It also offered opportunities to meet with a large number of women drug users informally in naturalistic settings. In addition, it impacted positively on making contact with potential interviewees. Between 1999 – 2002, 205 women and 100 workers, the majority of whom were met on more than one occasion, were contacted. In the context of fieldwork/observation, the research aims, strategy and process were explained and people verbally consented to engage in discussion. These discussions were not audio-recorded although notes were written up later. These were less formal interactions than in interviews. The venues were often the street, participants' homes and drug treatment agencies.

Spending time observing on the street and in agencies, alongside the use of interviews and focus groups, allowed me to informally interview and converse at length with a large number of people belonging to diverse groups, to observe people in the course of their everyday lives and in their natural settings of street and treatment centres, thereby increasing the possibilities of data, theory and methodological triangulation (Denzin, 1978, 1989; Mason, 2002). In summary the study was multi-method in its approach, drew from diverse data sources and used a number of perspectives in interpreting the data.

Ethical Issues

This study explores women's simultaneous experiences of drug use and motherhood, their lived experiences of drug-involved motherhood, a topic that is controversial, emotive, threatening and distressing. Revealing or disclosing things about oneself and drug use and parenting is an issue that needs careful consideration before participation. As a researcher wishing to explore with both women drug users and professional workers their thoughts, feelings and experiences of such a sensitive area, it was necessary to contemplate ethical standards and safeguards for all concerned, but particularly the women (Kellehear, 1989). Following in-depth discussion of the nature of the inquiry, informed consent was sought from individuals, whether interviewees, focus group participants or fieldwork contacts and their right to withdraw from the process at any stage was constantly reiterated. There was also an attempt to be precise and clear with each individual as to the potential use of these data in the future. That each individual's anonymity and confidentiality be respected was imperative, to the extent that certain details, events and characteristics were not mentioned in the text for fear of identification. The data, once gathered, were safely stored and anonymised.

Underlying all the ethical principles was one basic standard - no harm should come to those participating in the study as a result of their participation or as a result of the ultimate use of the findings. However, this is a hard standard to guarantee as researchers may have little control over how their findings are used by practitioners, policy makers or the media. If drugs research may be viewed in Foucauldian terms as a 'technology of government' (Martin & Stenner, 2004: 396), then the implications of how we carry out studies and what we do with the data are many. In the last chapter, it was noted that Famularo *et al.*'s (1992) caveats about their limited sampling strategy and its impact on their findings' generalisability have rarely been heeded by reviewers who have made far reaching claims about drug-using parents based on these findings. Reinarman & Levine (2004) also demonstrated how certain research findings were presented in the media creating moral panics and increasing harm to those affected by the issue. They highlighted how the US media misrepresented Chasnoff *et al.*'s (1985) study about prenatal drug exposure, despite its accompanying caveat about generalisations. Others have highlighted researchers' little or lack of control over the uses of findings in the media (Campbell, 2000; Kearney & Taylor, 2005). Campbell (2000: 219) indeed challenged researchers to turn their backs on exaggeration and sensationalisation of issues. Several authors have pointed out how contradictory or negative findings may actually harm those who have been the focus of such research (Barnard, 2005a; McKeganey, 2003). While it is hoped that the findings of this project will not further exacerbate the difficulties or further increase the vulnerability experienced by participants, the reality of lack of researcher control was discussed with the participants during fieldwork. However, simultaneously a commitment to do no intentional harm was stressed.

Some of the issues arising in the discussion of women's experience of drug use and motherhood proved to be painful and distressing ones. Women's drug use during pregnancy or while parenting may cause great distress and feelings of guilt and there have been differences noted among researchers about the drug use and extent of such use during pregnancy (Maher, 1997; Murphy & Rosenbaum, 1999; Rosenbaum, 1981a). Similarly, women's experiences of loss of pregnancies, neonatal deaths or loss of their children to the care of others were recounted at length during interview and proved very painful for some. Although a conscious decision to ask no direct questions about sexual or other forms of abuse was made and respected, many women raised this issue and when they did, it was discussed.[42] Some women were experiencing crisis situations and at moments I offered information particularly with regard to harm reduction and use of drugs and alcohol during pregnancy. On occasion, while involved in observation in particular agencies, I jumped roles from researcher to practitioner and played a support role where women were distressed or upset. At points, it was impossible to continue in an observational role or even with an interview, although it was in fact very rare. Above all, it was not possible (or indeed ethical) to simply conduct interviews, end abruptly and go. Care was taken about the ending of conversations,

[42] On one occasion in a group context a woman started to talk about having been raped some days earlier and I turned off the tape recorder.

interviews and focus groups, as it was in relation to leaving the field. It was not an abrupt departure.

All of those who participated in interviews and focus groups were adults. Two women met during fieldwork were less than 18 years old but they were not interviewed. The children of drug-using parents, with whom I retrospectively discussed some of their experiences, were all adult. An ethical decision was taken at the outset that no interviews or conversations would take place with children present.[43]

No payments were offered for interviews or participation nor were any requested.[44] However I sent or gave everyone who participated a thank you card and I was able to offer the women small gifts as appreciation for their time, effort, commitment and generosity. It has been noted that drug users wanted payments and in some cases were only there for the payments (Rosenbaum, 1981a). Others researchers have raised a range of concerns about this issue (Dickert & Grady, 1999; Fry & Dwyer, 2001; Seddon, 2005) and specific concerns about paying drug users for research participation because of how they might use that remuneration, for example, the purchase of drugs (McKeganey, 2001; Ritter *et al.*, 2003). In common with several other research projects (Finch, 1984; McKeganey, 2001; Mayock, 2000, 2003; Taylor, 1993; Wright *et al.*, 1998) this study's participants did not ask for payment, several stated that their incentive for involvement was a desire to talk about their situation and improve the lives of others. Many were embarrassed even when gifts were offered.[45]

Data Analysis

Analysis of the data was a lengthy process and involved making sense of, organising, coding and categorising. This process commenced as soon as fieldwork began. Organising, managing and sifting through the data involved constant comparison during the process of data collection so that

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[43] Informal discussions on the street and elsewhere with children present occurred but we deliberately agreed to refrain from discussing issues with regard to drug use or parenting with children present. Although I was not in a position to provide or pay for childcare, I was concerned about interviews taking place with babies and children present. In Klee & Jackson's study (1998) one researcher observed children's interest in various topics being discussed during interviews and expressed her surprise that the women interviewed did not understand the implications of this. However, the researcher appeared to have continued with the interview. The interviewer was also on one occasion present with a woman and child when the woman injected drugs during one of their meetings in the woman's home (Klee & Jackson, 1998: 66). As a researcher and former practitioner, carrying out research interviews with children present concerned me from an ethical point of view.

[44] By rights, however, it should not be assumed that they should participate for free. Seddon (2005) maintained that there are arguments for using incentive payments from justice, human rights and business perspectives. Many anomalies can occur in situations like this. One study reviewed (Smarsh Hogan *et al.*, 2006) involved 48 non-drug-using women, 72 drug-using mothers who were or had been in treatment, and 20 drug-using mothers who had refused treatment. Interestingly the mothers in the treatment group were not paid as research participants because involvement in research was a part of their treatment contract. On the other hand, the non-drug-using mothers and those who refused treatment were paid $25 for their participation at each stage of this longitudinal study.

[45] During data collection, which I carried out on a recent project exploring the experiences of women and men involved in prostitution in Dublin, none of the drug-using participants requested payment although it was offered. Two women interviewed specifically requested that their payment be donated instead to a 'Third World Charity' (CG&WS, forthcoming).

data gathering, coding, and analysis were not discrete moments following each other but occurred almost simultaneously. These processes often were crucial in informing one another and identifying patterns, trends, comparisons and contrasts. As an inductive endeavour, the grounded theory approach impacted in terms of the research process. Constant comparison, theoretical sampling, and memos were all utilised.

Mason (2002: 148) identified three ways or stages of reading data carried out by qualitative researchers or as Rubin and Rubin (2005) described it 'hearing data'. Data can be read literally, interpretatively and reflexively and all three stages were employed throughout. Carney's Ladder of Analytical Abstraction, as cited and illustrated in Miles & Huberman (1994: 92), adequately described the process. The first stage involved the sorting, summarising and packaging of data. This lengthy analytic process commenced as soon as contacts and interviews were underway. It involved listening again and again to recorded interviews, making field notes and writing analytical notes and memos after initial interviews, transcribing, hearing and engaging with the data, reading and rereading the transcripts and beginning to try out coding categories, coding the data and identifying both descriptive and conceptual codes and categories (Mason, 2002; Miles & Huberman, 1994; Strauss & Corbin, 1990, 1998) and indexing the data. More interviews and contacts followed and themes and codes were then revisited and comparisons and contrasts made. Transcribing such a volume of data proved to be an onerous task but crucial to the coding, categorising, thematising and analytical processes.[46] Each woman's account was taken as a unit of analysis, read, reread and revisited to identify codes, themes and concepts at different levels. Each professional worker's account was read in order to identify themes and patterns emerging. Themes were identified on the first reading of the transcripts and later revisited.

For various reasons a qualitative data analysis package was not used in the analysis of these data. A framework for analysis was created. While this presented a challenge in terms of organising and administering the data, I believed that it was crucial to constantly analyse and make linkages manually. While some argued that data analysis packages buttress the findings somewhat (Denzin & Lincoln, 1998), the arguments of another qualitative researcher (Mason, 2002) about the need to stay with and engage with the data in an effort to avoid considering the codes as variables or to become obsessed with counting were convincing. Key word searches, identifying relevant quotes and salient/recurrent themes, particular words, phrases and different stories told in the addiction treatment field were identified throughout. Counting was also carried out and as seen in the findings chapters, much of the data were counted as well as qualitatively analysed.

The next phase, or second stage, involved what Carney referred to as repackaging and aggregating the data. Here identifying analytical categories, themes and trends in the data and

[46] I transcribed all 60 interviews carried out with women drug users. I also transcribed the six focus groups with women and six focus groups with professionals, and 22 of the 40 interviews carried out with professionals. Eighteen interviews with professionals and two focus groups carried out with professionals were transcribed by a professional typist, with whom the issue of confidentiality was addressed.

searching for relationships in the data, writing analytical memos and identifying emphases or gaps were central. Initially the backdrop to the women's and workers' experiences, the social conditions of the study sites and the broader policy and treatment contexts were very pronounced, particularly in the accounts of workers during early interviews and as a result of observation. Informal contacts and further interviews with the women at a later stage of the process focused on the everyday realities of poverty, the relationships in the communities in which they lived, the challenges and obstacles they encountered and their interactions with services. However, soon their experiences of day-to-day life with their children, partners, families and friends began to emerge as crucial issues. Various processes began to become evident and a picture began to emerge.

The analysis continued in identifying themes coming out of the early reading of the transcripts. A thematic analysis, offering explanations and counter-explanations, was conducted in an effort to increase rigour. It will be seen that minority cases or views that considerably differ from the majority are constantly referred to throughout, particularly with regard to contentious themes such as fitness to parent and the nature of the drug-using mother.

During this phase the transcripts were once again read, reread and themes with regards to key processes, key moments and key actors were identified. Periodically these were revisited and an audit of codes was conducted. As codes emerged on reading later transcripts, it was necessary to return to the earlier transcripts on several occasions and recode for themes not identified on earlier readings. At the early stage, the fragmentation of the transcripts had been more focused on descriptive categories.

Initially 130 codes were noted in the transcripts relating to themes as diverse as socio-demographic details, involvement in drug use, experiences of pregnancy, numbers of children and involvement with services to interactions with key actors, key processes and key moments in the women's lives as mothers.[47]

Constantly returning to the research questions was also important in keeping focused as the data were raising many interesting and distracting issues, which were not specific to or relevant to the research questions. There were enough data for a thesis on women drug users' experience of

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[47] Key actors included - their parents and siblings in childhood and in adulthood; their extended family, friends and teachers in childhood; their children, partners, friends, peers and communities in adulthood; professional workers in drug treatment, social work and other services.
Key moments were described as - childhood, growing up, going to school, leaving school; using drugs; parents separating; first loves, pregnancy, birth; motherhood – having children, rearing children, losing children; entering drug treatment, becoming drug free; relationships ending - partners leaving, in prison or dying; their mothers' deaths; challenges in parenting everyday – managing poverty, managing stigma; challenges to parenting by family or services, loss of children to the care of others, approval of motherhood status/role.
Key processes included parentification, infantilisation, survival; monitoring, watching, challenging, loss of children; performance – giving birth/parenting, proving fitness, defending and justifying the role; giving a child voluntarily to the care of others, having a child taken into care, defending parenting. A key central process or overarching process of Preserving Motherhood was identified.

pregnancy and birth, or alternatively for a thesis on homelessness and insecurity of tenancy, or even on drug careers. The research questions served as a crucial and necessary disciplinarian focus.

The third stage in the process, developing and testing propositions to construct an explanatory framework involved both testing out the grounded theory emerging from the data and reducing the data to an analysis of trends, out of which emerged an explanatory framework. The analysis became process focused rather than solely descriptive and made connections between events, relationships between these key moments, processes and actors - interactions with partners, mothers, children, friends, workers; experiences such as becoming a mother; being a mother; performing motherhood. When the trajectory began to emerge as a picture, all the transcripts of the women and the professional workers were revisited in the light of the trajectory. Colour coding was then used throughout the transcripts highlighting the different moments/phases on the motherhood trajectory and the different experiences of different women at different stages. A diagram or map emerged which identified the various moments along a trajectory of drug-involved motherhood, described in the following chapters.

Throughout this period also member checking was carried out on an ongoing basis, hence enhancing the validity, reliability and credibility of the data. The trajectory was presented and discussed on a one-to-one basis with many individuals and in two of the fourteen focus groups. The findings describe the women's experience of motherhood and the professional workers' perceptions of the women's experience of the street life, the drug treatment system, the criminal justice system, the social work system, particularly the child protective services and the antenatal care systems. Although there was very early evidence of processes such as parentification, performance, infantilisation and survival, eventually a trajectory emerged from the data, a trajectory speaking of the women's collective experience.

The writing up period also permitted analysis to continue and during this stage, the trajectory was refined in the light of member checking and the data, the transcripts and field notes, were revisited on several occasions.

Generalisability, Reliability, Validity?

In qualitative research the issue of generalisability differs to quantitative research in that the researcher aims to describe the participants' experiences without claiming that their experiences are common to all members of the population of women drug users. These findings are particular and specific to the 205 women participants. However by all participant accounts, the trajectory described appears to be generalisable to an extent to the experience of not *all* women drug users, but to those who describe themselves as 'problematic', 'habitual' or 'addicted' users or former opiate users.

While it is not usual to employ such quantitative language in qualitative research, the numbers of women who participated, and the numbers of women in contact with the professional worker participants over their work lifetimes, perhaps might permit a cautious claim about the generalisability of many of the study's findings to the population of women drug users in Dublin, at least those who define as 'problem' drug users in contact with services.

From the outset, there was an emphasis on notions of audit trail, elimination of bias, checking for researcher effects, triangulation and member checking. Avoiding biases arising from both researcher effects on the site and the effects of the site on the researcher were kept central to the process (Miles & Huberman, 1994: 266). Minimising my impact or effect on the research site and the impact of the site on myself, as researcher, were important, as noted in another Dublin-based study (Mayock, 2003). Spending a lengthy period in the research sites, becoming as unobtrusive as possible, being clear about the research purpose and future uses of data, involving informants and consultants, interviewing offsite and recognising that I was 'not really such an important presence' in the participants' lives were all integral to the process of minimising researcher effects (Miles & Huberman, 1994: 266). In an effort to minimise the site effects on myself, as researcher, a number of strategies were adopted. A range of diverse informants was recruited, time was of necessity (because of my employment) spent away from the research site and including diverse and minority views were all strategies adopted. In addition, thinking conceptually, using consultants, using several data collection methods, checking out ideas with colleagues and keeping research questions in focus throughout were also employed, with varying degrees of success (ibid: 266).

As mentioned earlier, there was an attempt to incorporate several data sources and methods. Several ethnographies explored the lived experiences of women drug users. However, they accessed and recruited their participants through drug treatment centres or outreach workers. Additionally, they recruited only one group of respondents, the women drug users themselves and even though great diversity was observed within that group, there was only one data source, hence one set of accounts. The concept of triangulation (Denzin, 1978, 1989; Mason, 2002) allows for the incorporation of a number of viewpoints from different stances. However, rather than solving it all and bringing about validation, triangulation problematises interpretations and often brings additional insights into the analysis. Indeed including the accounts of the adult children of drug-using parents, for example, allowed for their view of the issues involved. In this way, differing insights into a phenomenon can be introduced or the researcher's analysis can be challenged and enhanced. Triangulation, therefore, contributes to the trustworthiness of the process and the inclusion of a range of views. It does not privilege or validate one participant's account at the expense of other participants' accounts or of the researcher's account. The final interpretation is always that of the researcher, in itself a problematic issue while in the pursuit of a participatory or emancipatory perspective.

The issue of 'truth', the reliability and veracity of the women's accounts and conflicting accounts have all been raised as concerns in this project, as they have in research with drug users generally and with drug-using parents specifically (Barnard, 2005a; Kearney *et al.,* 1994; Suchmann & Luthar, 2000). The audit trail is concerned with the trustworthiness and credibility of findings and how they have been guaranteed by the research procedures. Consultation with participants and member checking were employed throughout. Member checking is principally about giving participants the opportunity to revisit and think again about their contributions, to elaborate or further describe their experience in response to the interpretations of their previous interviews. Consequently, the researcher engages in revisiting, analysing and testing out the ongoing analysis in response to feedback. Member checking was particularly interesting when discussing emergent themes, the emerging grounded theory and the trajectory of preserving motherhood. This was done in a large number of instances with women and professional worker participants.

In this study, it is significant to note that the accounts of each group confirmed, affirmed and validated the many accounts of the other. However, two or three groups of participants were not selected in order to prove or disprove what the others were saying. Studies of women drug users using a range of data sources and data collection strategies are few. Although there are at points differences in accounts and emphasis, there is no objective evidence that one account is more 'truthful' than another. However it is reasonable to suggest that some accounts may be more privileged than others in the eyes or world views of different readers. Neither were professional workers selected to simply confirm the women's accounts because of their perceived unreliability. Issues with regard to 'truth', accuracy and honesty arose again and again. Several workers suggested caution about the criticisms of services offered by women drug users, while the women – who significantly in the main were not particularly critical of services - again and again emphasised that their accounts were truthful and honest.

While there may be assumptions that drug users' accounts are not reliable, there may also be a corresponding assumption that the accounts of professional workers are. However in his study of social worker's attitudes towards and knowledge about drug users, Adams (1999) observed the conflicting statements and views of the same social workers in questionnaires and interviews. He noted that respondents' tough and uncompromising answers in questionnaires were often modified significantly when faced by a colleague as interviewer, in follow up qualitative interviews.

Background and Insider Status

With regard to validity, Rosenbaum (1981a: 145) problematised how drug-using respondents may 'rewrite their experience' at different moments of their careers and to justify themselves to a 'nonaddict' interviewer. My position as a middle-class educated, never opiate 'addicted' Dublin woman, 'girl from the college' researcher, needs to be mentioned in the context of carrying out research with women predominantly working-class, early school leavers, all of whom have used drugs problematically. In terms of power, reflexivity and participatory approaches, an awareness

and recognition of my impact as a researcher and the impact of the experience on my life was crucial, in Maher's words 'forcing me to locate my own history and to confront my own privilege' (1997: 232). Concerns about power and inequalities between the researcher and those participating and attempts to equalise and level the playing field (Lynch, 1999, 2000; Mies, 1991; Oakley, 1981) led to my adoption of an approach incorporating emancipatory and participatory ideals. However questions remain about whether participation means merely consultation or total involvement. Within the context of a PhD project it is impossible to truly achieve this, if indeed it is ever possible. After all the final analysis and interpretation remains that of the researcher.

Challenges involving the methodological and ontological perspectives emerge throughout this chapter. While wanting to incorporate a participatory approach and ongoing involvement among the women and worker respondents involved, on completion of the interviews the majority of professional workers appeared to view them as completed. On the other hand, several other worker participants continued to express an interest in the outcomes of the analysis. Women participants were very active in their involvement and several were still offering insights to the point of submitting this thesis. Without a doubt, insider status (and mobile telephones!) facilitated ongoing contact with all groups of participants.

The issue of insider status presented a number of significant challenges to me in planning, designing and conducting this project, as mentioned on several occasions already. Without a doubt, where I was coming from impacted somewhat on the nature of the key research questions posed. An underlying feminist perspective had influenced my work with drug users, women and men, in the field and continued to follow me into this research endeavour. Many commentators focusing on epistemological and methodological issues have stressed the need to move away from a traditional and positivistic view of issues such as commitment, emotion, insider status and bias (Denzin & Linclon, 1998; Fonow & Cook, 1991; O'Neill, 2000; Punch, 1998; Reinharz, 1992; Stanley & Wise, 1993). The 'epistemology of insiderness' (Reinharz, 1992: 259) has led feminist scholars to attempt 'to rescue emotion from its discarded role in the creation of knowledge' (Fonow & Cook, 1991: 11). Epistemological issues are often complex but raise questions about who creates, owns and controls knowledge. Biases and assumptions are not synonymous with insider status. Insider status does not necessarily give rise to biases and assumptions in the same way as adopting a traditional, quantitative, highly structured, positivistic approach automatically precludes biases and assumptions entering into the design and conduct of a research project.

In my role as a drug worker working in a low threshold agency in inner-city Dublin between 1989 and 1997 and prior to that working in HIV organisations between 1986 and 1993 as a volunteer, I knew many women drug users a long time before I commenced this project. I also knew many professional workers in my previous role as drug worker and Director of an inner-city drug agency and my current role as Coordinator of the Diploma in Addiction Studies in Trinity College Dublin. As a result, unusually, gaining access, maintaining a field presence and establishing trust and

confidence among different groups were less contentious issues than those of reflexivity and objectivity. Mayock (2003: 81) described the task of accessing the field and maintaining a field presence as 'a daunting experience'. Other researchers have also identified many difficulties at this stage both in terms of access to, entering the field and recruiting women participants (Bowler, 1997; Gillies, 2006; Goode, 1999; Kearney & Taylor, 2005; Raine, 2001; Reay, 1995). However for me as a former practitioner, the prospect of going into the field, albeit a different field and in a different role as a researcher or fieldworker, was exciting rather than disconcerting. In terms of reflexivity, it should be noted that my previous professional role might have impacted on both the recruitment of participants and on the interviewing process with all groups of respondents. At moments I was the drug worker again instead of the 'girl from the university' (Richards & Emslie, 2000).

While in reality a 'university staff' member, I did however have a prior status within the drug treatment and community work world. Differences between 'university staff' and those being interviewed have been identified as key issues in several studies of drug-using parents. One study recruited peer or 'privileged access interviewers' to overcome difficulties suggesting as

> conceivable that given status differences (real, implied, or assumed) between those seen as 'university staff' and those from within drug-using cultures that a researcher would not be able to access non service-using drug-using parents to the same capacity. (Kearney & Taylor, 2005: 6)

While other researchers have noted the levels of fear and secrecy among substance-using mothers (Goode, 1999, 2000; Hogan, 1997; Kearney & Taylor, 2005; Raine, 2001; Taylor, 1993) and how that may impede access, this was not my experience. I believe my insider status and the women's references and testimonials on my behalf greatly assisted me in terms of access to the field, contacts with women I knew and introductions to those I did not. I found that several women, totally unknown to me before the fieldwork, actually approached me in the street to talk with me about the research. The women did not, it seems, observe me as threatening or judgemental and claimed to be able to talk about things that they found *'shameful'*. They talked about how they defended themselves or behaved defensively in many of their interactions with others. However I rarely had a sense that they were defending themselves in their discussions with me.[48] In the course of interviews, before I even had an opportunity to raise such an issue (although I had intended to), they invariably introduced discussion about how they defined good mothering, how they aspired to be good mothers, how in some cases they were good mothers and how in others or at other moments they fell short of the ideal.

[48] The study was not setting out to prove that women drug users were either good or bad mothers. It aimed simply to explore how they experienced motherhood and what it meant to them. However, people who did not know the women, had never met them, simply assumed that they were not good mothers because of their drug use involvement. My almost defensive attempts as a researcher to be patently clear in a sometimes overly mechanistic way in terms of aim and objectives, rationale, scope, limitations and use of a range of data generation methods and data sources appeared at times to mirror the women's defensive mothering.

The downside of insider status was the possibility of bias or others' perceptions of my potential bias. Possible and actual challenges about my position as being on the side of these fallen angels were anticipated and experienced, hence the importance attributed to both justifying and stating the research aim and objective, design and strategy throughout. While I had to constantly keep insider status and bias in mind, ultimately I believe that concerns about objectivity led to a more rigorous analysis of the data. However, this was time-consuming and consequently a lengthy period was spent in the field, gathering, analysing and verifying data.

I did not harbour concerns about safety, violence and health as discussed by several authors (Kearney & Taylor, 2005; Klee *et al.*, 1998; Maher, 1997; Rosenbaum, 1981a; Sterk, 1999a; Taylor; 1993). Indeed, whether the position of ethnographer or drug researcher is a suitable job for a woman has been discussed by a number of authors (Maher, 1997; Rosenbaum, 1981a; Taylor, 1993) with varying conclusions. Rosenbaum (1981a: 147) believed that as a woman fieldworker she was limited and attributed the small number of women ethnographers (in the late 1970s) to the belief that it is not a suitable job for women. Taylor (1993: 23), on the other hand, argued that it most certainly is, while Maher, surprisingly despite her own ethnographic endeavours on the streets of Brooklyn and later Sydney, appeared to initially concur with Rosenbaum. However she then suggested that it is not a question of whether 'ethnography is a suitable job for a woman, but rather a question of which women and under what conditions' (1997: 222). Interestingly several researchers of a similar background to my own as volunteers, workers and practitioners did not express concerns about safety and danger (Boyd, 1999; Sargent, 1992). Throughout the fieldwork period, I never felt in any danger and did not experience any occurrence that was untoward. The 'drug world' is not that separate or different from the regular everyday world, although it is often sensationalised and presented that way by the media and ethnographers (Campbell, 2000). I also found much of what happened in drug agencies and on the street as 'normal'. However I had worked for a long period in the field and was perhaps inured or immune to some of its everyday events. Murphy (1992) described how she missed things initially while carrying out her research because she actually had too much experience as a researcher in the area and had to unlearn some of what she had known.

Insider status enhanced the possibility of checking back with participants and evaluating their experience over time. The women and workers also offered continuous challenges, feedback and ideas. I was also aware of the difficulties that often reportedly beset research with drug users and was never unduly concerned when interviews and appointments were cancelled or rearranged. Many of the women's children, partners, families, friends and networks were known to me before the fieldwork period and not only did the women facilitate entry to the field but their partners, children and family members often spoke with me too.

Limitations

Having initially in Chapter One mentioned the scope and limitations of the study, I wish to also look at methodological limitations at the close of this discussion. While the number of women contacted during the research period was quite large, these were not randomly selected participants. Rather they were alternately theoretically sampled, purposively sampled and recruited through snowball sampling or chain referral. The sample of those interviewed in-depth (26) on a number of occasions and those met in focus groups (44), amounting to 70 women, represented a little more than one third of the total number of 205 women met in the course of the project. While there are limitations in extrapolating from small samples, however, several data sources and participants with extensive direct and indirect experience of the issues were involved. In addition, it could be argued that there is an overrepresentation of women who are more radically affected by problem drug use and associated problems.

Reports were retrospective as all reports are. However it is important to note that there was a heterogeneous group of women representing differing experiences of motherhood at different ages and stages of their mothering and drug use careers.

Conclusion

This chapter has presented a descriptive, illustrative and reflexive account of the methodological issues and concerns associated with this project, my 'tale from the field'. It outlined the theoretical frameworks, epistemological issues and ontological viewpoints concerned with this study. The proposal, design, data gathering, analysis and write up phases of this study were described as was the consultation process engaged in with the participants, both women drug users and professional workers, throughout the endeavour. Issues of insider status, ethical concerns and standards, objectivity, internal validity and broader questions of generalisabilty have been considered, while methodological and ethical issues arising in other studies of women drug users informed the discussion.

The study adopted a qualitative approach, attempting to offer a detailed account and understanding of mothering and motherhood from the point of view of the lived experience of women drug users. The fieldwork phase was carried out over a three and a half year period, during which the researcher was in constant, direct contact with a large number of women drug users, at varying stages of their drug-using and parenting careers. Contact with professional workers was also maintained. Theoretical sampling, in-depth and semi-structured interviewing and various 'conversations with a purpose', focus groups, participant observation, triangulation of methods and data sources, constant comparison, memo writing and member checking were all components of this study.

This chapter links the theoretical positions with regard to women, drug use and motherhood outlined in Chapter Two to the following chapters, Chapters Four to Eight, which present and discuss the findings of this study.

CHAPTER FOUR

MOTHERHOOD OBSERVED, REHEARSED, ANTICIPATED & ACHIEVED: FROM GIRLHOOD TO WOMANHOOD

> Almost all contemporary cultures conflate femininity and maternity and then idealise and denigrate both. ... Mothers inevitably internalise society's ambivalence about maternity and this may particularly affect their mothering of daughters (women and mothers-to-be), both in the early provision for the infant and in providing the environment within which the capacity to 'play', to be 'creative' and to become a person in her own right, will be formed. (Ernst, 1997:80)

This chapter, the first of five that discuss women drug users' motherhood experiences, introduces the findings of the research endeavour, the nature of which was described in Chapter Three. Sixty in-depth interviews with 26 women and 40 interviews with professional workers were carried out, from which much of the following material discussed is drawn. These accounts are supplemented by data gathered from observation, a further 44 women focus group participants, 135 street contacts and 60 professional workers, focus group participants and contacts. What follows in this and subsequent chapters is an account of a trajectory of drug-involved motherhood charting the women's experiences of childhood, pregnancy, birth, drug use, parenting, occasional loss of motherhood role and interaction with drug treatment and social work services.

This chapter initially introduces the women participants and presents the trajectory of drug-involved motherhood that emerged from the accounts, providing a framework for the reporting and discussion of the findings. The remaining chapter charts the women's experiences during childhood and teenage years, culminating in their transitions to adulthood. Their childhood memories and relationships with their parents and siblings are described in the first section, as are their educational and victimisation experiences. Then in the following three sections their entries during teenage years into drug use and motherhood careers and their relationships with their families in the aftermath of having become drug-using mothers are examined. It concludes following an assessment of their experiences.

The women participants

The 205 women involved in this study ranged between 16 and 48 years of age. Of the 26 interviewed and the 44 who participated in focus groups all were between 18 and 44 years.[49] Collectively, 193 women were mothers of 442 living children ranging in age from infancy to independence, some living with them and some in the care of others. In addition four women, two

[49] The 26 women interviewed in this study are introduced in Appendix II, while each of the 205 women encountered, 193 of whom were mothers (94.14%), are identified by pseudonym, age, drug-using status, parenting involvement and number of children in Appendix III. A profile of the women appears in Appendix IV.

interviewees, one focus group member and one contact were caring for other people's children, involving a further seven children.[50] In total 24 women (11.70%) of the 205 women met in the course of the study were pregnant, three for the first time.

The 26 women interviewed were the mothers of 64 living children, while two of the 26 were caring for four 'foster' children, ranging in age from 6 months to 24 years.[51] Seven women were non-custodial mothers, that is, their children were in the care of others, either kinship or foster care. Five women had one or more of their children in out of home care, but each was caring for at least one of their children. Thirteen women were living with all of their minor children and one woman's children were now adults.

The 205 women reported varying drug use and drug treatment histories. More than half (53.65%) or 110 women were methadone maintained at first meeting, 21 women (a little over 10%) were drug free and 74 women (a little over 36%) were currently using street drugs. However although the majority of focus group participants were in contact with treatment agencies and a small minority were drug free, a large number of street contacts were either currently using, in and out of treatment, or on treatment currently.

Of the 26 women interviewed, 16 (61.53%) were on methadone maintenance, five were using street drugs (19.23%) and five were drug free (19.23%) and described themselves as *'in recovery'*. Two women were drug free at first interview, using at the second and reinstated on methadone programmes at the third. In this and following chapters, accounts of initiation into drug use and the drug careers of the women will be described and discussed while their drug histories and careers will be reviewed particularly in the context of their parenting careers. Sixteen women were Hepatitis C positive, five of whom were also HIV antibody positive. Eight women were HIV negative and HCV negative, while two women did not know their HIV/HCV status.

Although a small minority of the women encountered did not fit the stereotype of the poor, working-class, inner-city woman drug user discussed in much of the Irish literature (Butler & Woods, 1992; Carmody & McEvoy, 1994; Dunne, 1995; Farrell, 2001; Keenan *et al.*, 1993; Lawless, 2002; O'Connor *et al.*, 1988; O'Neill, 1994), the majority of the women did. They had been reared in inner-city areas, lived in local authority housing, as part of large families in which they often took responsibility for other siblings and as a result some attended school infrequently. Where the sample deviated from this norm, it was rare with several women hailing from middle-class Dublin backgrounds and others coming from a relatively comfortable rural background or a background

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[50] Information about the women's reproductive histories, their children and childcare arrangements is presented in Appendix VI, VII, VIII and IX.

[51] At first interview 15 of the 68 children were under four years, four of whom were less than one year and 11 were between one and four years. 28 children were aged between four and 12 years, 15 between four and eight years while 13 were between nine and 12 years. This is significant as internationally children of drug-using parents of primary school age represent an often under-researched age group when compared with their infant or adolescent counterparts (Hogan, 1997). Sixteen children were aged between 13 and 17 years and nine were 18 years and more.

overseas. Whereas no formal measure of socio-economic status was used, nevertheless much information about their parents' occupations, the women's participation in education, housing situations as children and adults, and their employment involvement was gathered.[52]

The Trajectory of Drug-Involved Motherhood

The accounts offered by both the women and the professional workers demonstrate the centrality of their experiences of childhood, teenage years and the transitions to drug use and motherhood, and early adulthood to their experiences of drug-involved motherhood. All described the pathways through drug use and parenting as a tenuous process. Hence presented is a diagram (Figure 1 – p.102) charting these pathways through drug-involved motherhood. This trajectory maps their experiences as mothers arising from the interactions between them[53] and other significant key players, their parents, partners, professional workers and the perceptions of society at large.[54] Five strategies were evident – learning the role, performing the role, defending the role and justifying the role and above all aspiring to be the 'Good Mother', in order to keep and maintain the role. Women drug users believe that they must, and are reported by professional workers as always having to, engage in these strategies.

Their movements through drug use and parenting are viewed as a series of processes described in the five findings chapters. This chapter will outline the experiences of the women in this study as they observed their own mothers' performances and demonstrations of motherhood, experienced being mothered and their subsequent rehearsal and apprenticeship as 'little mothers'. It then continues in highlighting how the women anticipated, attained and welcomed motherhood, emphasising how as women drug users they were unwelcomed to motherhood often by family members and treatment providers. Subsequent chapters will emphasise how the women performed motherhood, idealising good motherhood, defending and justifying their own performances, while highlighting the actions of others as idealising, prescribing, watching, monitoring and challenging their motherhood roles. The experiences of some women who successfully defended, justified, maintained or retrieved a lost motherhood role are recounted, as are those who lost their role. This trajectory illustrates the ongoing interactions, both actual and symbolic, between key actors in this story of drug use and motherhood. The women's 'master status' as drug users in the eyes of others despite their self-definition as mothers represents the key problematic in this study.

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[52] See Appendix IV

[53] Motherhood observed, rehearsed; Motherhood anticipated; Motherhood achieved and welcomed; Motherhood performed; Motherhood defended and justified; Motherhood lost, relinquished; Motherhood retrieved, recovered or regained; and Motherhood preserved

[54] Motherhood performed and demonstrated; Motherhood idealised; Motherhood prescribed; Motherhood unwelcomed and unapproved; Motherhood watched and monitored; Motherhood challenged; Motherhood approved; Motherhood interrupted or terminated; Motherhood restored.

Figure 1 - Trajectory of Drug-Involved Motherhood – Preserving Motherhood

Motherhood Observed & Rehearsed – Chapter 4
(Childhood/Teenage Years)

Motherhood Anticipated - Chapter 4
(Pregnancy)

Motherhood Achieved/Welcomed - Chapter 4
(Birth)

Outcomes after birth following interventions by family members or professional service providers:

Motherhood delayed
(Baby retained in hospital pending decisions about health/care arrangements)

Motherhood terminated/interrupted
(Baby placed in care of others)
Chapter 4

Motherhood Watched/Monitored
(Baby left in care of mother – to be monitored)

Motherhood Performed/Defended – Chapters 5 & 6
(Parenting – Performing/Defending/justifying
at various stages of the drug-using career while watched/monitored by partners/parents and professional service providers)

Outcomes as a result of performance surveilled and interventions by family members, partners or professional service providers:

Motherhood Upheld/Approved
(Justifying/Maintaining Motherhood)

Motherhood interrupted/terminated
(Losing Motherhood)
Chapter 7

Motherhood retrieved/regained
(Recovering Motherhood)

Motherhood Idealised – Chapter 8
(Aspiring to good motherhood/fit parenthood - Preserving Motherhood)

Childhood experiences – Motherhood Observed & Rehearsed

> *Daddy was drinking the money. Ma was out working... and it was all about no money and poverty at that time.* [Andrea]

This first section relates the participants' accounts of women drug users' experiences as children. Where many other researchers have tended not to ask drug users and drug-using mothers specifically about their childhood and their own experiences of being parented, this study adopted a different approach and explored these experiences using a life history question at the start of interviews.

Focusing on childhood experiences, the impact of neglect and abuse experiences particularly, and their impact on individuals in adulthood has been regarded as 'taboo for discussion' (Klein *et al.*, 2007: 40). Most qualitative and ethnographic studies of male or female drug users, it seems, traditionally viewed childhood as irrelevant to the drug-using career (Boyd, 1999; Maher, 1997; Rosenbaum, 1981a; Taylor, 1993), believing that such discussion implies a speculative causal connection between adverse childhood experiences and adult drug use.[55] However, recently there has been more interest in assessing the impact of early life experiences on adulthood, some of it specifically focusing on the experiences of those reared in families where alcohol and drug use was an issue, as noted in the literature review. While many of those who experienced adversity as children have not experienced problem substance use or other difficulties in adulthood, it has been suggested that a significant number have and that the risk is greater (Howe, 2005; McKeganey *et al.*, 2003; Velleman & Orford, 1999). Other drug researchers, however, have described the childhood experiences of women drug users (Friedman & Alicea, 2001; Goode, 1999; Murphy, 1992; Murphy & Rosenbaum, 1999; Neale, 2002; Sargent, 1992; Sterk, 1999a).[56] More recently, traumatic and childhood experiences of problem drug users, particularly sexual abuse, have invited attention from researchers (Browne *et al.*, 1998; Christo & Morris, 2004; Etherington, 2006; McKeganey *et al.*, 2005; Maier & Lachman, 2000; O'Neill, 1994; Rohsenow *et al.*, 1988; Wilson, 1998; Wincup, 2000).

In relating childhood experiences, including those of poverty and victimisation, the women in this study were not offering explanations or excuses for their later drug use. Rather they made connections between their childhood experiences and their own mothering performance and career later in their lives. However, at the outset, it is important to stress that the levels of childhood adversity reportedly experienced by the vast majority of participants - interviewees, focus group members and contacts encountered during fieldwork observation – are notable. The women themselves rejected the label of victim generally and did not minimise or underestimate their personal choice or responsibility with regard to drug use. Yet, by all accounts, there appear to be strong connections between childhood experiences of family difficulties and socio-economic

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[55] These studies generally commenced with the 'getting in' (Rosenbaum, 1981a), or 'starting off' (Taylor, 1993) stage or initiation as the beginning of the career in drug use.

[56] Neale (2002: 49) significantly entitled her chapter as 'Initial Drug Use and Childhood Memories'.

disadvantage on the one hand and drug use on the other. Significantly, a majority of professional workers suggested causal relationships between women drug users' early childhood experiences of adversity, neglect and trauma and later drug use. They also suggested that their early experiences of having been parented impacted on their later involvement in parenting and their parenting styles.

The women's accounts of the start of their journey towards drug use and motherhood are related in this chapter. During interviews when asked to describe their experiences of motherhood, they outlined the importance of being mothers and doing motherhood, emphasising the symbolic significance of motherhood in their families and communities. They drew on descriptions and memories of their mothers, grandmothers, and other people's mothers and on their experiences of having been mothered. They discussed their childhood as a time during which they learned what it was to be a woman and a mother.

Five key issues arose in their accounts of childhood. Their mothers' example of being hardworking mothers, managing poverty and busy households, often in the absence of husbands/partners was a common theme, as was the women's experience of parental affection, discipline, supervision and the meeting of their basic needs. Experiences of abuse and victimisation at the hands of family members and others were related, although unsolicited by the researcher. Educational experiences were discussed at length, as were their experiences of 'parentification' and the adoption of roles as 'little mothers'.

The women's accounts of childhood

Most women were reared by their parents, and in the majority of cases, both parents lived in the family home during their early years. However some were reared part-time at the very least by their grandmothers and several were moved to the care of their grandmothers as children. Varying accounts of childhood years unfolded, ranging from *'happy'* childhoods (in the case of ten women) or *'fine', 'OK'* (five women) to *'traumatic, I'd have to say, traumatic'* [Katherine], in the case of eleven women.

However when women considered their experiences, many issues emerged and often those who described their childhoods as *'OK'* or even *'happy'* revealed adversity. Professing love for their parents and siblings, many believed resolutely that their parents loved and cherished them. Recalling either happy or sad memories, the women focused on events, such as Christmas or holidays, First Communions, Confirmation and the summer months.

> *My childhood was the best hood I had. Like I was, we were spoiled kids. ... We used to get everything off me mother, everything! Like I really bow down to her because she really looked after us really well.* [Jenny]

Some described positive childhood experiences mentioning all that they had received from parents and stressing the warmth and maternal nature of their mothers. Others described happy childhood moments even when overall their childhood was difficult.

Some offered entertaining accounts of families struggling to *'survive on the little money we get'* and *'make ends meet'* despite adversity, to enjoy Christmas, birthdays, and other events. Others mentioned that no matter what occurred in their families, they were taken on holiday every summer.

> *Even though there was all kinds of shit going on in my home life, no matter what would happen that still would happen, those two weeks of the year, that there was a focus on the kids...* [Ellen]

However while they often preferred not to focus on these adverse experiences, they were very affected by them. Overall, accounts focused on the unavailability, absence or presence of one or both parents, being treated as different from other siblings or experiencing indifference, being labelled as a victim or a villain – the good sister or the bad sister.

Interactions with parents were often fraught, some women talking about the hatred they felt towards their mothers. Some women specifically mentioned the role their grandmothers played in their lives, for example, one woman, Rachel lived with her grandmother for a long period as a child while another, Ethna was moved by social work services as a result of neglect and abuse at nine years to her grandmother's care, where she remained for four years. Interestingly those who experienced difficulties in their relationships with their mothers declared that they *'idolised'* and *'adored'* their fathers. However, although their relationships with fathers were important, the women often told stories about absent or only occasionally present fathers, a phenomenon also observed in many studies of families generally and in families impacted by drug use specifically (Murphy-Lawless, 2002; Rosenbaum, 1981a; Stanton, Todd *et al.*, 1982). Some experienced more warmth, affection and approval from fathers, even if they were often drinking, errant and regularly *'out of the picture'*. Other fathers were physically present, sometimes almost omnipresent, controlling and/or violent, while being emotionally distant or absent. This was stressed by workers too. Their pivotal relationships, problematic or not, were with their mothers.

Twelve women (46.15%) reported that their parents had separated during their childhood or teenage years and 11 (42.30%) reported that at least one parent was now deceased. With the exception of one woman, whose mother died when she was 16 years old, others had not experienced the loss through death of a parent during childhood years.[57]

Parental alcohol use, particularly among fathers, was mentioned. Fifteen fathers (57.69%) had been problem drinkers during the women's childhoods. Varied drinking histories were reported and several fathers eventually stopped drinking and *'found recovery'*.

> *I grew up with an alcoholic father. My mother was addicted to him and all the madness that went with that, like violence and abuse and in many shapes and*

[57] Many women met in the course of fieldwork mentioned the death of a parent during childhood. O'Neill's (1994) study of emancipator education in a Dublin based women's project profiled a group of ten participants and found that nine women had lost one or both parents through death before the age of 13 years. Childhood traumas such as early parental loss and separation and their consequences for well-being in adulthood have been noted among drug users (Maier & Lachman, 2000).

> *many forms. We lived in flats and it wasn't going on in everybody's home but it was going on in a lot of people's homes. So it was kind of normal, if that makes sense.* [Katherine]

> *Dad was a ferocious drinker like. He always loved the drink. Mam loved drinking in the beginning. But you know and my aunt and granny used to mind us and they'd be off and they'd be having crack and I'm sure they enjoyed themselves. But then as we got older, Mam cut down on it and Dad got more into it... And then eventually Mam got sick of it and she said she was leaving him if he didn't stop altogether and he did, fair play to him and he never looked back.* [Brenda]

In addition, five mothers (19.23%) had been problem drinkers, four drinking alongside their problem drinking husbands included in the group mentioned above, while one was the sole drinker in the family. Sixteen families (61.53%) in total were exposed to parental alcohol use. In one family, one mother also developed a significant problem with tranquilliser use and gambling. Other women reported that their mothers used tranquillisers and anti-depressants to cope but did not define this use as problematic.

Twelve women identified their vulnerability as children, having experienced violence or emotional distance from their mothers. Ellen described a contentious relationship with her mother, experiencing violence first hand.

> *I mean I came from a family where my father worked all the time. My mother stayed at home ...My father never drank and neither did my mother. But it was quite a violent upbringing and I would've been the one that would've been reacting towards that.*

Arlene also highlighted her unrecognised vulnerability and described her feelings of *'not fitting in'* - *'I never felt at home'*. Regarded as difficult, rebellious and reacting children they believed they were viewed as *'troublemakers'* and *'rebellious'* rather than *'troubled'* and often regarded as the *'bad sister'* or *'bad daughter'*.

Several women highlighted the lack of communication, openness and basic instruction about sexuality, menstruation, self-care, health and *'about periods and things'*. Significantly, one woman described her mother as *'no model mother'* [Susie], highlighting what many women identified. They were adamant about wanting to *'do it differently'* with their own children, to communicate, to be involved in their lives, wanting to know about their education, their friends, their *'little concerns'* [Participants, Focus Group 4].

Others also described difficult relationships with their very *'busy busy'* or emotionally distant mothers. Several women argued that while basic needs were met, other emotional needs were neglected or indeed violence was experienced. Some hinted at and others openly acknowledged the indifference, coldness and emotional distance they experienced from their mothers. Several talked about the gap between, on the one hand, having physical needs met and, on the other, a distance and coldness from their mothers.

Oh my needs were looked after. I was in Clark's shoes and you know that kind of thing. But the emotional wasn't there at all. [Laura]

And I remember havin' the best of everythin', the best clothes and the best home to live in, but always gettin' thrown out or always gettin' clattered for nothing ... I ended up in hospital a lot. [Arlene]

Many families were under pressure. Mothers were frequently absent due to involvement in work of necessity. Consequently, their daughters lacked contact with their overworked, stressed mothers who were constantly managing poverty, households, limited material resources and family difficulties, alongside holding down trading and cleaning jobs.

I never remember me mother huggin' me even. She hadn't the bleedin' time, the woman, when I think about it, do you know what I mean? [Katherine]

Although many reported problematic relationships with mothers, most believed that their mothers tried their best to provide for them, protect them and to rear and educate them. They respected their mothers' determination to struggle on and survive, despite the losses of contact, boundaries and warmth incurred. Several women mentioned the lack of supervision and discipline, for example Andrea described her mother's total struggle to care for her eight children while simultaneously going out to work as a cleaner at several different times of the day. Katherine mentioned that there was little time for any affective attention.

Several women described their mothers as busy, unapproachable, always angry and concluded that their mothers were *not 'able for us'*. Throughout, however, they mentioned the difficulties their mothers experienced in life while other women struggled to understand the social conditions in which their mothers had lived and cared for their families. According to a considerable number, their mothers' pressures and their unavailability to their children was often due to the hopelessness of their fathers as breadwinners. In many cases what impacted on their fathers' ability to earn was their alcohol use and their *'philandering'*.

...the ol' fella was that fond of the drink that he wouldn't come home half of the time. Or else when he did come home, he was stupid drunk. Me Da wouldn't give me Ma the wages. [Rachel]

Sometimes this emerged with regard to the women's partners also as seen later. *'Hard working women'* and *'lazy men'* were mentioned throughout the women's and professional workers' accounts.

Being ashamed of living in poverty and always worrying about money and food and the like were also described. Dealing with moneylenders and the *'relieving officer'*[58] was also a regular occurrence for many families.

The unemployment for generations, the drink, the violence and the hard work of making ends meet, day in, day out, week in week out. Getting food on the

[58] Community Welfare Officer

table, clothes on our back, shoes on our feet - our Mas had to deal with that. Where the old fellas were, I don't know. [Amy]

Others also emphasised the lack of regular income and resources in their homes. Their mothers' attempts to earn money through cleaning jobs, selling goods, borrowing from moneylenders, buying necessities *'on tick'* were all described, as were successes and failures at balancing the tight budgets and making ends meet. Significantly, their lives later mirrored those of their mothers.

Throughout, they discussed difficulties that their own mothers had experienced in life and were aware of their mothers' difficult life experiences.[59] Although these participants may not have presented themselves as 'wildly unmothered' (Goode, 1999: 115), it is fair to say that they generally identified their own experiences of being mothered as being problematic and unsatisfactory, and that most of them were anxious to *'do it differently'* with their own children.

Other women struggled to understand their mothers' lives and the social conditions in which they had lived and cared for their families. Some women still felt significant anger that their mothers stayed with drinking and violent husbands. So it is a case of, as Anderson (1994) and Ettorre suggested 'women are damned if they drink and damned if their husbands drink' (1992: 5), as indeed are both the women in this study and their mothers before them.

One issue which arose repeatedly throughout both the women's and professional workers' accounts was the experience of being *'old too soon'* or having *'old heads on young shoulders'*. Many talked about their experiences of caring for their parents, watching out for their siblings, particularly younger siblings, and taking on many responsibilities in the home. Women and workers interviewed talked about the *'little mother'* and echoed the findings of another study among women drug users in which as girls they became 'surrogate mothers' and were involved with what was described as 'other-mothering' (Friedman & Alicea, 2001: 85).

> *But like from a young age there's lots of expectations placed on girls to be mothers, to have babies and to even babysitting you know. They babysit from a very young age and they're expected to get the shopping and to look after grannies and stuff. And they're only kids themselves really. And I think boys, there's almost an expectation that the boys are going to be out on the streets, getting into trouble and the girls are going to be looking after others, the carers.* [Social Worker, W 37]

This experience has also been described in the literature as 'parentification', where there are expectations on the part of parents that children will play a quasi-parental role in the family system (Barnett & Parker, 1998; Boszormenyi-Nagy & Spark, 1973). It has often been observed in families affected by addiction problems (Barker & Hunt, 2004; Barnett & Parker, 1998; Bekir *et al.*, 1993; Kelley *et al.*, 2007; Laybourne *et al.*, 1996). While this will come up again and again throughout this

[59] Their understanding of their mothers' struggles - to manage poverty, their dependence on substances; experiences of loss and grief; the impact of social constraints on women in the Irish context, the lack of contraception and the number of pregnancies endured or their mothers' experiences of domestic violence and problems with husbands who caused major difficulties - was evident in their accounts.

study, it is useful to note here that the women as adults reported, as did others, their experiences of parentification as children. Both women and workers were concerned that the transgenerational reproduction of these patterns and processes might and did occur. The impact of this parentification on the girls' participation in the education system was reported, as was the later tendency to rebel and yearn for fewer responsibilities. Many also stressed that older children often took the role willingly in order to protect and prevent the maltreatment of younger brothers and sisters. Indeed women frequently reported *'bearing the brunt of it all'*, including abuse, in order to ensure their younger siblings' safety.

Experience of adversity – abuse, physical violence, sexual abuse

> *Very few have actually identified a happy childhood, and when I say that, it may not be issues like just separation or whatever, it is actually abuse a lot of the time that they have experienced.* [Refuge Worker, W 14]

> *For me, the root of drug abuse, a lot of it was rooted in sexual abuse or serious bereavement as children, you know, separation from parents and sexual abuse....* [Social Worker, W 37]

As mentioned earlier, research has pointed to a connection between illicit drug use and experiences of physical and sexual abuse, one Irish study reporting earlier onset of drug use among those abused (Browne *et al.*, 1998). The professional workers interviewed believed that many women drug users had endured unhappy childhoods with much adversity, describing their experiences of violence, severe punishments, physical beatings, physical abuse, sexual abuse, rape and neglect. In addition to professional workers' accounts, 16 women interviewed (61.53%) described experiences of abuse during childhood.

Sexual abuse was mentioned regularly, many referring to the *'unspoken histories'* of the women concerned. Many workers identified sexual abuse as a central issue in the lives of almost all the female clients encountered in their services.

> *I don't think I met a woman drug user who was an injector who hadn't been abused or raped somewhere in their career.* [Addiction Counsellor, W 02]

In terms of sexual abuse during childhood, 13 women (50%) referred to their own experiences of abuse.[60] While several women reported sexual abuse by neighbours and family friends, several acknowledged sexual abuse by family members, identifying fathers and brothers as the perpetrators.

Frances recalled how sexual abuse impacted upon her education and teenage years when her academic performance started to deteriorate rapidly.

> *I suppose poor concentration, maybe not sleeping at nights, maybe worrying at nighttime ...It had been going on from when we were a very young age...Maybe it was more of understanding dawned because when you do get*

[60] Some did so within minutes of the interview commencing. The other 13 women either stated categorically that they had not been sexually abused or they did not refer to it at all.

into your teenage years you do become more aware of your body and what's right and what's wrong ... and so I mean, yeah, they were very disturbing, those years.

Large numbers of women mentioned sexual abuse on a one-to-one basis during informal meetings also. However, while topics such as prostitution and sexual abuse arose in the more public arena of focus groups with the women, these were generally discussed as *'issues'* rather than as personal experiences.

Thirteen women (50%) experienced physical abuse during childhood/teenage years.[61] Four women experienced violence at the hands of their mothers only, while five women experienced violence from their fathers only.

Battered! I was battered morning, noon and night! My mother hated me, she did. She never stopped and I did everything for her. [Amy]

We lived in fear of him coming home at night. He was often violent against us all. So that wasn't good. Eventually me Ma had to get him out. [Maeve]

Four women reported experiencing violence at the hands of both their mother and father. Eight mothers and 10 fathers were described as having been violent.

Fifteen (57.69%) reported experiences of emotional abuse and some specifically mentioned forms of neglect.

Yeah I remember being left outside of the door waitin' for her, you know, at six o'clock at night, waitin' for me dinner and you'd get no dinner because she had gambled the money away. [Marina]

However, on the basis of their accounts, it appears that several women who did not accept a label of having experienced emotional abuse or neglect in fact described experiences uncannily similar to those who specifically acknowledged this experience. Their accounts of indifference and emotional disconnectedness from parents were telling.

Eleven women (42.30%) experienced all three types of abuse - sexual abuse, physical violence and emotional abuse.

I was abused. Mentally, emotionally, physically, sexually ...I have vague memories around some incidents. I remember a lot from my childhood. ... There was so much fuckin' secrecy. Nobody talked about anything and probably lack of protection to, yeah obviously. [Katherine]

Two women experienced physical and emotional abuse. One woman experienced both sexual abuse and emotional abuse and one woman experienced sexual abuse only. It is interesting to

[61] Thirteen women either did not refer to physical abuse or said that they had not been abused and the majority of those said their relationships with parents during childhood were good.

note that of the eight women who reported experiences of rape and sexual abuse as adults, all but one[62] had experienced all types of abuse during childhood.

Fear of their parents, and in several cases fear of their violent fathers was often extreme. Fourteen women (53.84%) witnessed or experienced violence between their parents in the home of the family of origin, while twelve women (46.15%) had no experience of domestic violence in their families. There were a number of women, some who experienced abuse and others who did not, who witnessed violence and other forms of abuse against their siblings.

Some specifically mentioned the strain and pain of seeing parents experience violence. Some witnessed their mothers' experience of violence while others spoke of their fathers' experience of abuse at the hand of their mothers.

> *Me Da used to beat me Ma, you know, things like that. Now I mean, like Jesus, bangs of hatchets into the head and things like that.* [Helen]

However even those with brutal experiences were often able to identify positive experiences and protective factors during their childhood. Many described experiencing fun, happiness, mentioned Christmas, birthdays, First Communion. Echoing a large number of the women, Frances said, *'We had an OK childhood'*. However she continued:

> *It was a very dysfunctional one, you know, through sexual abuse. All of us yeah. And all of my brothers and sisters had to do a lot of work on their childhood as they got older and had to do a lot of counselling to resolve issues.*

While questions about victimisation, sexual abuse or any other form of violence, abuse and neglect were not directly posed during fieldwork, almost all women mentioned these experiences, usually briefly. Workers nonetheless emphasised this issue constantly, many claiming that the vast majority of women drug users experienced abuse as children. They also often attributed the women's involvement in drug use to these experiences. Several worker respondents[63] differed in their suggestions that there are certain *'mantras'* about negative childhood experiences reiterated by the women, perhaps as a way of justifying or minimising their adult behaviour.

> *People in adversity, which often they are, their substance misuse creates quite a considerable amount of adversity for them – people may paint the past in more... darker colours!... But having said all that, I must say I am struck again and again by sometimes by the horror of the stories that people tell.* [Medical Practitioner, W 29]

However, while the women talked of how they often minimised and denied their drug use involvement to protect their respectability, emphasise their responsible natures and to guard their motherhood role and status, childhood victimisation was hardly ever offered by the women as a

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[62] Liz did not report any experiences of abuse during childhood although she acknowledged her experience of the 'little mother' role. Perhaps it is also interesting to note that seven of the eight women who experienced rape in adulthood also worked in prostitution. Ethna was the only one of this group who had not worked in prostitution at any stage of her drug-using career.

[63] W 04 and W 29

reason for teenage and adult drug use. The majority of workers regarded women drug users as victims, victimised by their families in childhood and by partners and others in adulthood. The women, conversely, often viewed themselves as survivors and resisters.

This tension between the workers' views of the women as victims and the women's accounts of themselves in the main as survivors persists throughout and has also been played out in the literature. Childhood victimisation of women has often been discussed in the drugs and crime literature, its effects seen as persisting into adult life leading to the self-medication thesis (Maher, 1997). Others have focused on the victimisation of women by 'doctors, dealers and darlings- the three d's' - in teenage and adult years when they begin to use drugs (Ettorre, 1992; Johnson & Auerbach, 1984) or described women drug users as 'substance abused women' (Bolla, 1996). Several other studies have shown high levels of abuse experiences among drug users, both men and women in Dublin and Scotland (Browne *et al.,* 1998; McKeganey *et al.*, 2005). By all accounts, the number of women reporting abuse of any kind is high. While more than 60% or 16 of the 26 women interviewed revealed experiences of abuse during childhood, many women met during fieldwork also mentioned abusive experiences. Half of the women interviewed reported experiences of sexual abuse, while workers suggest that as many of 95% of their clients have experienced sexual abuse. A large study of sexual abuse in Ireland reported that one in five women and one in six men experienced sexual abuse (McGee *et al.,* 2002). Even in the context of these high reported figures in Ireland, the large number of women in this study reporting sexual abuse is notable.

Several women acknowledged severe abuse as central to their experience. While sometimes angry about their experiences of having been parented and their exposure to abuse, some found this a difficult issue to explore. Mindful throughout of the needs of women as a social group and the concept of gender as central to the analysis (Ettorre, 1992:1), it is significant to highlight that the women themselves rejected mother-blaming or woman blaming in the context of lack of protection. Rather they more often made excuses for parents who either abused or did not provide protection from abuse. Many of the positive experiences in the face of such adversity occurred in school.

School and Education

Many workers expressed concerns about the educational attainment of their clients, noting the extreme difficulties experienced in terms of literacy. Lack of participation in primary or secondary education due to these young girls' housekeeping responsibilities was mentioned.

> *It's quite frightening and dropping out of school at like ten years of age to mind the kids. ... OK well some of them maybe were boisterous at school maybe, or acting out that wasn't acceptable ... but in a lot of cases they were applying themselves to school.* [Nurse/Outreach Worker, W 10]

Most women reported their own early school leaving and poor educational attainment, 20 (76.92%) having left school on or before the then official school leaving age of 15 years and only four women

(15.38%) leaving school with a qualification of Leaving Certificate or better.[64] Among the 26 women, the average age of leaving school was 14.26 years.[65] Many reported experiences of suspension or expulsion from school.

Some offered very positive accounts of their schooldays, identifying school as a powerful influence, as an escape and a protective factor. As Katherine said:

> *I loved school. It was the one place where I could pretend I was fuckin' something else or feel I was achievin' something or I was a good person or whatever, you know... But it was a safety net. It helped me to keep my sanity ...I never went on the mitch in my life.... It was an escape though. It gave me something to focus on rather than the madness of what I was living with and the abuse and the violence and all that.*

For those who liked school the pressure to leave early or the fact that they were not encouraged to continue with their education was regrettable. While she loved school and valued education, Helen left school a few weeks before she was due to sit the Junior Certificate examination.

> *It's one thing that makes me mad is what me ma done, she didn't pay me exam fees. So I couldn't do the exam.*

Others also left early. Susie loved school and had *'great fun there but left just after* (her) *Confirmation'*. Emma too acknowledged the importance of school in her life and the fact that it brought her in contact with girls, as she had no sisters. Andrea also talked about her school days positively. However she left school early for social reasons.

> *Yeah I had liked school. I had a big interest in it. I loved teachers! I always was a lick arse in school .... And they'd show me there's another way. It wasn't all about flats ....Me Ma would make sure she'd get back from work, get us all out to school... But I always felt I can't half be here because there was no money at home ... And it was like "right get out" and the first I done, I forged me birth cert and I got took on FAS[66] so I could bring money home.*

Eleven (42.30%) women described their experiences in school as bad, saying that they did not like school. Six others described their schooldays as *'OK'*, *'not bad' or 'boring'*. However while liking school very much, some women acknowledged that they had not done well in school. Frances liked school and did well, her performance only deteriorating during her teens. While others described *'scapegoating'*, bullying, always being in trouble and being punished, they however viewed the positive sides of getting away from a home life that was difficult.

> *School was OK. But I had nuns you know the way. I was always gettin' smacked for nothin' you know, for the smallest of things. Now when I see the nuns now like it was like, you'd think she was after givin' me the best education. School was alright. It got me out of the house. I'd be kept out a lot as well. I was kept out because of me Ma.* [Arlene]

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[64] In total four completed both Junior Certificate and Leaving Certificate examinations while three completed their Junior Certificate/Intermediate Certificate examinations.

[65] Two women had left school at 12 years. Eight women left school at 13 years. Seven left school at 14 years. Three left school at 15 years. Two left school at 16 years. Four left school at 17 years.

[66] Community-based employment scheme

Several women expressed anger about their losses in terms of education due to their involvement with childcare at an early age, some only discovering their abilities when attending school while incarcerated or participating in training programmes. Lack of participation in primary and secondary education due to parentifcation and 'little mother' responsibilities was mentioned by many. Both involvement with care of siblings and having children at a young age introduced many women to adult roles for which they were unprepared. The effects of early motherhood were many, impacting on education, drug use and their identity. Several explicitly related their early school leaving to their early pregnancies. These findings among young women echo the findings of studies on parentification reviewed by Barnett & Parker (1998). Significantly in one of the earliest comparison studies of drug-using, methadone-maintained mothers and non-drug-using mothers, the only difference between the two groups of women was that the comparison group was more likely to have completed their schooling (Colten, 1982).

The early leaving of school among the study participants is significantly higher than the findings of a range of HRB studies in the Irish context with regard to the reported early school leaving of those who are in contact with the drug treatment services. In 1991, 42% of treated drug users were early school leavers (O'Hare & O'Brien, 1993) and in 1994, early school leavers accounted for 41% of those treated (O'Higgins & O'Brien, 1995). A more recent study suggested that this has begun to change somewhat with early school leavers representing between 28.4% - 30.9% of all cases receiving treatment in the HSE Eastern Region in the years 1998 – 2002 (Kelly *et al,* 2005).

The importance of school as a protective factor with regard to a range of issues has been acknowledged in the literature (Gilligan, 1998, 2000). While the women and workers suggested a number of reasons for poor performance at school, there appears to be a close relationship between age at first use of drugs or escalation of use and leaving school. A recent study highlighting the issue of early school leaving found that 51.1% of a large survey population had tried using drugs before they had left school and 46.5% believed that this drug use had affected them while at school (Comiskey, 2003). Other studies have also described the link between drug use and early school leaving (Bowden, 1997b; Butler, 2002a; Dean *et al.*, 1983). Interestingly, there appeared often to be a strong connection between leaving school and using drugs, either starting to use shortly before or after leaving the educational system. In several cases there is a clear connection between leaving school and becoming pregnant. In some cases also some women described their problem drug taking as commencing shortly after the birth of a child. In some situations there is a strong connection between all three events. However, almost all aspired to and were not surprised, disturbed or overwhelmed by these early transitions.

Teenage years – Motherhood Rehearsed & Anticipated

As teenagers, the women became involved in romantic and sexual relationships, their social networks expanding beyond immediate family circles and school contacts. While most reported increased freedom, many combined several roles, one woman describing herself as *'your typical*

house angel, street devil'. Several avoided the role of the often-mentioned *'little mother'*. However 17 women (65.38%) absolutely adopted this role, following early training in responsibility, watching out for others, their parents, siblings and grandparents. The taking on of the motherly role during early teenage years has been documented in other studies of women drug users, offenders and girl gang members (Joe & Chesney-Lind, 1995; Joe Laidler & Hunt, 2001; Kearney *et al.,* 1994). Financial contributions to families were expected of some. Several described early introductions to shoplifting and others, although not expected to do so, left school early to work and make their contribution. Some looked after themselves while their mothers were under pressure, overworked, had large families. Alternatively several women, usually younger sisters cared for by older sisters, were expected to do nothing other than being a child, going to school, playing, being looked after.

Nonetheless, the women described these responsibilities as protective factors, preventing total immersion and involvement with drug use and crime. Being the eldest or the only girl in their families meant that responsibilities were many. School attendance and completion invariably suffered. Experiences of parentification also impacted negatively on their involvement in social, cultural and sporting activities as children and teenagers.

They offered a litany of accounts of rehearsing motherhood for various reasons, several mentioning a mother's ill health, constant pregnancies, or addiction, for example three women mentioned their mothers' alcohol use. However, by far the commonest reason for the *'little mother'* role and parentification was their mothers' involvement without support, childcare and for very little money in menial jobs outside the home, as noted earlier.

> *What happened to me, I was the mother figure in the house looking after the brothers cause my mother was out (working) to keep the house going for bills, for food.* [Emma]

Others too described how they *'went wild'* whenever they could escape these restrictions, for example Elaine outlined how the eldest of five, she looked after her younger siblings from an early age. Expected to *'keep house'* as a result she often missed school, went wild at night, but she conformed at home and continued the *'little mother'* role until she became pregnant. Katherine was also expected to assist her hard working mother and cared for her sister on an ongoing basis. However, unlike many of the others, she actually managed to combine home, school work, *'going wild'* and completed her Leaving Certificate examination.

> *So I remember being in the last year of school and just thinking "I fuckin' don't want this responsibility" or whatever. Cause I also had younger siblings that I used to look after. My mother worked and my father fuckin' just drank and there was murder all the time.*

Many women and professional workers suggested that girls living in poor conditions with stressed mothers and absent fathers ended up as the primary carers of their siblings and lost their childhood. Their *'model mothers'* provided them with many examples of what women do within their families and communities, highlighting traditional and gendered expectations. Many professional workers mentioned that their mothers were their role models, who *'put up'* with abusive

relationships and gave them a clear message - *'well this is what women do'* [Medical Practitioner, W 30]. While boys sometimes experienced parentification and early responsibilities also[67], it seems reasonable to suggest that by all accounts this was greatly accentuated for girls. They had little opportunity to be children, to be curious, to learn and have fun.

> *Women aren't valued, girls aren't valued and very often not properly nurtured and their need to nurture "I'll have a child and I'll nurture". ... You get entrée in the adult world by having a child and you get respect. So it is an act of resistance.* [Community Worker, W 34]

They believed that in becoming a mother, there was independence, freedom, autonomy, respect, status and identity.

> *Actually I remember getting pregnant and really the relief. I mean, I wanted to have the baby. But I think the reason I wanted to have a baby was because I knew it was the one thing that'd get me out of the house.* [Ellen]

On the other hand, many stayed with their families of origin. *'Pleasing'* their mothers and *'fixing'* things for them were also priorities for many women, some of whom remained all their lives devoted to their mothers and aware of their many difficulties. Several women who had been 'little mothers' became mothers as teenagers, while others made the transition to motherhood later in their early twenties. Notably for some, their attempts to retire from the little mothering career and start another as mother of their own children were often thwarted. Some managed to combine careers simultaneously as *'little mother'* and *'real mother'*, while others attempted to do so for a while, some eventually losing both roles. Some found that their mothering career was denied almost from the outset with the most strident campaigners against them in that role, their own mothers.

Initiation into drug use - 'no one put a gun to my head'

> *If someone was to say to me, "what was your teenage years like?" It would be all just drugs, drugs, drugs.* [Susie]

> *We done things, Jesus, that I'm not a bit proud to say now.* [Arlene]

This section briefly describes substance use initiation accounts related by the women, overviews the women's age on initiation and the explanations, causes, reasons they raised and the discourses they drew upon to describe initial and early use. Focusing on their use of alcohol, non-opiate and opiate-based drugs, it refers to the transition to opiate use – the process of becoming a drug user – initiation. The diverse accounts both concurred with and differed from those of other studies. To do justice to the following accounts of becoming a user, however, is not possible in a small part of a chapter.

The women's accounts of drug initiation and acquiring the 'master status' of drug user (Becker, 1963) favoured a range of explanations and diverse pathways. They highlighted their

[67] Several women, for example Amy, Katherine and Rachel, described their brothers' responsibilities and the taking on of a *'little father'* role particularly where their father was absent or drunk all the time.

purposefulness and active involvement in drug taking, echoing many studies (Friedman & Alicea, 1995, 2001; Henderson, 1999; Maher, 1995a, 1997; Mayock, 2000, 2003; Morgan & Joe, 1996, 1997; Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993). In focusing on the 'fluid' nature of drug use across time, Mayock (2000: 97) aptly stated, 'there is nothing inevitable about a drug career'. This too was mirrored in their accounts.

Teenage years heralded a time of testing boundaries. While wanting to retain their mothers' approval and protect their *'little mother'* roles, they simultaneously rebelled against things which *'were cramping my style'* [Avril]. Some resented how the *'fella's got off scot free'* [Arlene] as they witnessed the freedom, absence of supervision and lack of responsibilities experienced by their brothers and boyfriends. Some women reported how their activities and movements were overseen and reported on by brothers and neighbourhood youth. There was less support and fewer chances when they encountered difficulties with drug use or criminal activity.

> *In terms of families and in terms of how that woman drug user is viewed within the other systems I think then it's much different - they're viewed as much more devious or their behaviour I think is examined more than a male drug user's behaviour is.* [Addiction Counsellor, W 19]

The women described initiation into drug use, their increasing realisation that they were dependent on these substances and their inundation into the life. Alcohol was in every case the first drug used, other than nicotine[68], the age at first use ranging from 4 to 15 years, the average age 13.23 years.[69] All but one of the women (96.15%) participating started to use illicit drugs during teenage years[70], the age at first use ranged from 12 to 22 years, the average age 14.76 years. Cannabis was the first illicit drug used by 19 women (73.07%).[71]

Several were mothers past their teenage years before their first opiate use[72], one woman having reached 32 years of age before her first encounter with heroin. Nevertheless, 22 women (84.61%) started using opiates during teenage years, 18 of whom were 17 years or younger. Age at first opiate use ranged from 12 – 32 years, the average age 17 years.[73]

This is consistent with other Irish and international research that suggests that heroin users and problem drug users generally start drug use careers at an early age (Faupel, 1991; Maher, 1997;

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[68] All but two women smoked cigarettes and had commenced smoking before their illicit drug taking commenced.

[69] One woman first consumed alcohol at four years; one at 11 years; one at 12 years; ten at 13 years; eight at 14 years and five at 15 years.

[70] One woman first used illicit drugs (non-opiates) at 12 years; six women used at 13 years; five at 14 years; eight at 15 years; three at 16 years; two at 17 years; and one at 22 years.

[71] In several cases their first use of a non-opiate illicit drug was actually preceded by opiate or cocaine use.

[72] Six (23.07%) of the 26 women did not use heroin before the birth of their first child. Indeed Ethna did not use until well after the births of her two children. Another woman, Sharon had used heroin on several occasions as a teenager but did not use it again and encountered no problems with drug use until after the birth of her fourth child, although her partner was a user.

[73] One woman used opiates for the first time at twelve years; two women used at 13 years; two at 14 years; six at 15 years; two at 16 years; five at 17 years; one at 18 years; three at 19; one at 20; two at 21 years; and one woman started opiate use at 32 years of age.

Mayock, 2003; Neale, 2002; Rosenbaum, 1981a; Sargent, 1992; Taylor, 1993). The HRB studies revealed the average age of first use of the main problem drug of the majority of those in receipt of treatment in the Eastern region and in Ireland generally as in their mid to late teens – the median age 15 (range 11 – 24) (Kelly *et al.,* 2005; Long, Lynn & Kelly, 2005). In her study of young people's drug use, Mayock (2000) found that average age of first use for drug takers was 13.2 years and for problem drugtakers 12.4 years. All her interviewees were teenagers at the time of interview and recalling more recent initiation during the mid to late 1990s. The women in this study ranged from 18–44 years, were all involved with problematic opiate use and their initiation occurred over a range of decades, several women commencing in the late 1970s or early 1980s. As a result different drug use and career profiles emerged, perhaps explaining the slightly higher average age at first use of illicit drugs. Neale's (2002: 13) Glaswegian study of 200 male and female drug users reported a mean age of 16 years (range 5 – 32) while the mean age at first use of heroin or cocaine for Maher's 45 women participants was 18.9 years (1997: 31).

Seven women (26.92%) described their first illicit drug of use as heroin or cocaine. Their accounts identified availability of these drugs in their social circles as a key reason for use. Women living in areas of high availability reported early use at 12 or 13 years, for example as Avril said, *'It's just outside your door'*. In other cases, their proximity to a ready supply or drug dealing in their families and within their homes facilitated early use. Conversely, one woman from a rural area first encountered heroin and other drugs at university at 17 years[74], while another woman from a rural background did not commence opiate use until her thirties.

Lengthy recreational careers sometimes preceded heroin use, long periods elapsing between a recreational career and a later heroin-using career. It was not always an automatic linear progression from drug taking to problem drug taking, as seen in Mayock's studies (2000, 2003). Involvement in different types of use involved different milieux, people and attitudes. Many drank alcohol and smoked cannabis from an early age while their use of heroin did not commence until late teens or early twenties. In other cases, heroin was the first drug used by several people. Nevertheless, all the women became problem drug takers at some stage. Eleven women (42.30%), now methadone maintained, viewed themselves as *'clean'*, *'stable'* or *'off drugs'* while continuing to use cannabis, and sometimes ecstasy or cocaine, recreationally as a *'treat'*. Cannabis use was regarded as commonplace. The majority drank alcohol with the exception of three women *'in recovery'* and another woman, at the time undergoing detoxification.

Discussion of initiation elicited diverse explanations. Both women and workers drew on a range of discourses and even theoretical and interpretative frameworks to explain women's drug use. Some women evoked images of seduction while describing their *'descent'* or *'falling'*. Older women suggested that younger women *'should know better',* while both older and younger women, when

[74] However, the availability of alcohol in Brenda's family owned pub meant she had access to alcohol from 4 – 9 years of age at which she took her confirmation *'pledge'* to abstain from alcohol until adulthood.

probed, described their own initiation into drug taking as being purposeful, fun and involving choice. Availability, curiosity, wanting to have fun, escape, self-medication, and iatrogenic use were all mentioned. Some workers presented women's drug use as a form of deviance, others as evidence of psychopathology, as a coping strategy, while some suggested that it might be a form of resistance in itself.

> *There was a kind of innocence about it, about the times they did it, for birthday parties and birthday presents as well. But I think at a group level, at a peer level it could be deemed resistance ...* [Community Worker, W 05]

Predominantly, the women's accounts highlighted availability, curiosity and wanting to have fun as reasons for their initiation as do many other accounts (Ettorre, 1992; Maher, 1997; Mayock, 2000, 2003; Rosenbaum, 1981a; Sargent, 1992; Taylor, 1993). However, even where many described their purposeful drug choices and decision-making, they almost all acknowledged that these decisions were made from a limited menu of choices about their lives. Many offered more than one reason for their drug taking and continued their use because of *'feeling good'*, *'feeling stronger'*, *'feeling a sense of belonging'*, *'increased confidence'*, and *'loving it'*.

Espousing a self-medication theory, several women claimed that without drugs they would simply have not survived the adversity they had experienced. Notably, all of those offering such an explanation experienced sexual abuse in childhood. Some mentioned the importance of drug and alcohol use as a coping mechanism, *'to get by on a daily basis'* [Frances].

> *I think I'd've committed suicide or done serious damage to myself if I hadn't found drugs, ... I think drugs at that time saved me, ironic as it sounds.* [Katherine]

Commencing regular drug taking much later than many after several years of childrearing, Sharon too espoused a self-medication explanation.

> *What actually happened to me, how I got strung out on heroin was that after I had my fourth baby I didn't realise that I was going through postnatal depression ... It hit me with a ton of bricks. But unfortunately instead of going to the doctor I was chasing the dragon and that was knocking it out of my head.*

However some simultaneously acknowledged the influence of others and the pleasure associated with drug taking. Sometimes the women offered a number of explanations or possible reasons and motivations for using drugs, ranging from pleasure seeking to coping.

Some described first use in mixed groups or all-girl groups of friends. Several women described their first use at 12 years with friends.

> *Yeah we started together, the four of us from school. It's mad isn't it? We're all on methadone with babies now.* [Susie]

Others mentioned that their friends started and that they eventually followed. Arlene described her initial reluctance to use drugs and her gradual initiation into heroin use at 13 years.

> *But they'd be usin' and I'd be "No, No, No!" Then one day I was lookin' at them out of it and I just said "Go on the, give me some". .... And then when I got it,*

the first one I took honestly I'd say I was strung out from the first time I took drugs. I wanted it! I forgot all. It blocked everything out of me.

While some mentioned the bad influence of peers, others specifically acknowledged that they chose that peer group. Significantly many women described how the boys or men in these groups tried to exclude them from using or give them less, saying *'It's not for the girls'*. Often this gendered attitude was one the women were determined to challenge.

> *One night before we were going out, one of the lads was chopping up, it was gear, in the corner on a mirror. I didn't know what it was, you know. "What's that? Can I have some?" "No! No, the girls can't have any! The girls can't have any!" which was of course like a red rag to a bull. It made me want it even more.* [Liz]

Consistent with previous research about initiation into drug use highlighted earlier, almost all started using with their peers, many of whom did not go on to become problem drug takers, and described their voluntary participation and purposeful engagement with drug use. Although it was rare that older relatives had an involvement in initiation, one woman described her first use of heroin at 15 years in her uncle's company.

Only four women (15.38%) started using opiates later than teenage years. Already a mother, Laura began to use heroin with friends and became immersed in a drug career. *'A very late starter in every way'*, Ethna's first use of heroin occurred at 32 years when her two girl friends offered her *'a skinpop of heroin'* after her father's death.

Twenty-one women (80.76%) described their first use of alcohol, drugs generally and opiates specifically as occurring in groups, mostly mixed gender groups, sometimes including their own siblings. Seven women described their first use of opiates occurring in single sex groups, while eleven described their use commencing in mixed sex peer groups.[75] One woman described her first use of heroin occurring with an older relative. One woman described her use as self-medication following earlier medication by the family doctor. Only six women described their first opiate use as occurring either alone or in groups along with their boyfriends.

Almost all emphasised their agency, purposefulness and choice in terms of taking drugs. This was particularly emphasised by women who hailed from more affluent areas. Echoing a range of earlier studies which found that drug availability contributes to experimentation and initiation (Binion, 1982; Chein *et al.*, 1964; Cuskey, 1982; Eldred & Washington, 1976; Maher, 1995, 1997; Mayock, 2000, 2003; Parker *et al.*, 1988; Reed, 1985; Rosenbaum, 1981a; Taylor, 1993; Waldorf 1973), many women claimed that availability of drugs within socio-economically impoverished communities sometimes influenced their initiation and some started using at an earlier age, several identifying heroin as their first illicit drug of use. Their socio-economic circumstances did not in of themselves

[75] Although Sharon's occasional use of heroin at 16 years occurred in a mixed group context which included her future husband, when she started to use heroin again ten years later, it was her partner who supplied the heroin and with whom she used in the privacy of her own home.

dictate that they used drugs. After all, many had siblings and friends who, raised in the same context, made different choices about drug taking. However the possibility of exposure was greater in working-class areas than in middle-class or rural locations and associated with disadvantage, as seen in successive HRB reports, policy documents and other studies (Butler, 1991, 1997, 2002a; Dean *et al.,* 1983; *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* 1996; Mayock, 2000, 2003), discussed in Chapter One.

The vast majority, both younger and older women, did not commence their use with partners. This differs from other studies (Maher, 1995a, 1997; Rosenbaum, 1981a; Sargent, 1992). Gendered expectations of their families and communities affected their involvement also. Often the only way to drink and use drugs was to engage in these activities with other girlfriends or their sisters.[76] In some cases their mixed groups of companions did not include their boyfriends who indeed often disapproved of their involvement in drug taking. Their brothers, male associates, *'neighbourhood fellas'* appeared to have a strong vested interest in keeping their women *'clean'* or as one woman said *'cleaning and on the straight and narrow'* [Amy].

Despite the widespread belief among workers that *'female drug users a product of their male partner'*, that women *'get dragged into drug use by a male partner'* [Workers – Focus Group 1] and *'in the pecking order women inject themselves after the male and there's more risk because of that'* [Medical Practitioner, W 29], the women's accounts challenged these simplistic assertions. Their experiences suggested that a range of dynamics was occurring with regard to initial, subsequent and ongoing use, again mirroring other research findings (Klee, 1997; Maher, 1995a,1997; Sterk, 1999a; Taylor, 1993).

Some described their partners as significant with regard to impacting on their initial use, suggesting that their partners were instrumental in their initiation. While *'he didn't put a gun to my head',* Emma attributed her introduction to cocaine and heroin use at 17 years to her then partner, her first child's father. Janet talked of being *'forced into drug abuse'* at 15 years by her child's father. Others started along with their partners but argued that they were not forced to do so. Indeed Jenny highlighted how her wanting to use was so unquenchable. '*So then I couldn't feed me habit and he couldn't feed me habit. So we just got on to the clinic'.*

Proximity to a dealing boyfriend, *'me first love'*, who Johnson & Auerbach (1984) might describe as a dealing darling, offered Wendy an opportunity to use as it was *'always there'.* Darina's dealing darling on the other hand did not supply her need for drugs and she used in secret as he opposed her use, which was an experience mentioned by several women. Some women emphatically rejected that their partners facilitated or encouraged their use.

[76] Although 20 women (76.92%) were the only female opiate users in their families, many had other sisters who used alcohol and other drugs.

> *Everybody thinks he's dragged me into this life and I'm the one who's dragged him into it, you know. And he fought me every step of the way. God love him! ... He was definitely thought of as the bad boy. But he wasn't.* [Brenda]

Several commenced drug use while their partners were in prison. Many discussed their partners' disapproval of their involvement in such activities, some mentioning their negative judgements about those using drugs or on methadone. Others, seven in total, asserted fervently that they made their choices each step of the way. While she acknowledged that gender differences in initiation occur, Ellen for example consistently stressed that it was her curiosity, which lead her largely male peer group into heavier use. After her child's birth she made a decision that this group's activities posed risks for her child and instead she connected with one man who was a heroin user. However her heroin use predated her involvement with him.

Their accounts of often commencing within mixed or all girl groups rather than with partners, however, significantly challenge earlier accounts regarding men's involvement and influence on women's initiation into and continued involvement in drug taking (Binion, 1982; Cuskey, 1982; Eldred & Washington, 1976; Ettorre, 1992; Hser, Anglin & McGlothlin, 1987; Reed, 1985; Rosenbaum, 1981a, 1981b, 1981c; Sargent, 1992; Waldorf, 1973). Some women, who encountered first use at a later age, rejected the notion that their partners introduced them to drug use, also differing from other research concerning older women initiates (Rosenbaum, 1981a; Sargent, 1992; Taylor, 1993). However they acknowledged increased opportunities, even surreptitiously, for use because of their proximity to using partners. Some women met in the course of fieldwork experienced the 'if-you-cannot-beat-them-join-them' scenario (Sargent, 1992: 87). Generally the women suggested that their partners often had little to do with facilitating their use, suggesting that their partners did not approve of their drug involvement, as has been reported by others (Klee, 1996)

The women were not lured or seduced into drug use by their partners, boyfriends, '*first loves*', their darlings or even their dealing darlings. Indeed their dealing darlings were even more disapproving of their use. Many guarded their use with secrecy. Many met heroin-using partners post-initiation. The importance of their partners or young men in initiation was perhaps overstated by professional workers. My study's findings with regard to initiation have more in common with recent studies that portray women's involvement in drug use as far from passive (Denton, 2001; Henderson, 1993a, 1993b, 1994, 1999; Klee, 1996; Maher, 1995a; Mayock, 2000, 2003; Taylor, 1993).

Lives using drugs ensued. Initiation and immersion in a drug-using lifestyle was often more difficult for girls and women than for their male counterparts and partners. However, all agreed that life was considerably easier prior to having children.

> *Women drug users who aren't mothers ... they're like tough tomboys, at it with the lads or being one of the lads. And maybe that's OK to be like that for a while when you're in the height of and the flight of your drug use and you're being streetwise and you're able to do the robbing and you're able to do all those things that the men are able to do.* [Social Worker, W 01]

Several women suggested that there was little they would change about their lives, including their drug use.[77] Some described themselves as stupid or *'dense'* for starting to take drugs, claiming that they were unaware of the consequences, they *'hadn't got a clue'* when first offered drugs. However, others were clear that they knew exactly what they were doing.

With few exceptions, the women regretted their involvement in drug use and all viewed their subsequent immersion into drug use with sadness, despite the fun, curiosity and pleasure derived in the initial stages. They regretted the drug taking *'because of where I ended up because of drugs'* [Darina]. The majority acknowledged that their previous ability to make choices and decisions about drug taking and their lives was affected by their increasing need for heroin, sentiments also identified in another Irish study (Mayock, 2000, 2003). The discourse of regret and rueful reminiscences persists throughout discussion of their life experiences, particularly with regard to becoming mothers and involvement in motherhood. Additional difficulties arose when the transition to motherhood was encountered.

From 'Little Mother' to Motherhood

> *For many of them who do become parents when they're far too young it's just a natural progression as they see it. They were looking after their younger brothers and sisters from a very early age so it's no big deal that then they would have a baby when they're 15 or 16.* [Medical Practitioner, W 30]

Pregnancy, birth and becoming a mother proved to be the most crucial transition for the women and indeed a full chapter, even a thesis, would probably not do justice to the number of issues that arose in discussing these experiences. This section will summarise the main experiences related and discuss the symbolic nature of this transition. Pregnancy and birth represented transition to *'real'* or *'proper'* motherhood for many girls who had played the *'little mother'* role. Many respondents claimed that they regarded attaining motherhood as simultaneously achieving womanhood. This mirrored Irish and international accounts, suggesting that transitions to adulthood and establishing feminine identity are often marked by pregnancy, birth and the transition to motherhood (Butler & Woods, 1992; Chodorow, 1978; Griffin, 1985; Hannan & O'Riain, 1993; McCashin, 1996; McMahon, 1995; Murphy, 1992; Murphy & Rosenbaum, 1999; Oakley, 1980; O'Connor, 1998; Sterk, 1999a).

The women's experiences of pregnancy and birth as drug users span three decades.[78] The 26 women had 76 pregnancies between them,[79] resulting in the live births of 64 children. Several women were pregnant during the course of the study, some for the first time, others for the second,

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[77] Brenda; Ellen. However perhaps it is arguable that they did not lose as much as others due to their participation in drug use. Their motherhood careers were not interrupted or terminated as a result of any fallout from their drug use.

[78] Twelve women (46.15%) gave birth during the 1980s; 17 women (65.38%) gave birth, some on several occasions, during the 1990s and seven women (26.92%) have given birth during 2000 and since.

[79] Four were twin pregnancies, three of which ended in miscarriage or stillbirth.

third, or even fifth or sixth time.[80] Several women had traumatic endings to their pregnancies, such as terminations, miscarriages or stillbirths. Some experienced a neonatal death or a sudden infant death. Indeed in several cases this occurred to women on several pregnancies. Several women had *'small'* babies. Several babies were exposed to HIV or Hepatitis C *in utero* or during birth, although none of the children were HIV antibody positive. Others gave birth to healthy babies, with good birth weights but sometimes the babies experienced withdrawals. Others' babies experienced no withdrawal or Neonatal Abstinence Syndrome (NAS) symptoms at all.

These pregnancies and births were crucial moments, a *'life changing experience'* or *'turning point'* in many women's lives. For some women, loss of pregnancy was the precipitating event preceding their drug use or their escalation of use. For others the loss caused major changes in lifestyle, one woman becoming totally drug free after her experience. Many others found their way to treatment.

Pregnancy - Motherhood Anticipated

Becoming pregnant, while otherwise welcome, created difficulties because of their drug use. Women only expressed concerns about the timing of these first pregnancies in terms of drug use and the potential impact on the foetus or on their capacity to parent. Ultimately, these pregnancies appeared either to motivate or further stress the women with regards to their drug use, as noted elsewhere (Colten, 1982; Deren, 1986; Eldred *et al.*, 1974; Goode, 1994; Pursley-Crotteau, 2001; Rosenbaum, 1979, 1981a). Six (23.07%) women had their first experience of pregnancy and birth before they used opiates, while one woman (3.84%) gave birth to both her children before commencing drug use. The majority, however, experienced some or all of their pregnancies as opiate users or in treatment for opiate use.

Most pregnancies were unplanned but far from unwanted. Some women intended to become pregnant at some stage. Andrea described meeting the community's expectations and becoming a mother as *'something one did'*.

> *The cycle was unmarried mothers, you got pregnant, you had your baby and you got a book and that's how you were paid.*

Along with many others, she demonstrated an unquestioning acceptance of the reality and inevitability of motherhood, saying that she *'wasn't somebody that planned on having kids. They came. I accepted them'*. Most assumed that becoming pregnant and giving birth was normal and anticipated this eventuality, planned or unplanned.

Others had tried, desperately in some cases, to become pregnant for some time.

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[80] During the fieldwork period one woman interviewed (Sheila) was pregnant. She was the mother of three children, currently in her sister's care. It was her fifth pregnancy. She gave birth after the end of the fieldwork period. Five women who participated in focus groups were pregnant, two of whom gave birth during the fieldwork period. Eighteen women met during fieldwork were pregnant, three of whom were expecting their first children. In total, 24 women (11.70%) of the 205 women met in the course of the study were pregnant.

We were trying for ages... Seven months later I found out I was pregnant. ... So we were delighted. The two of us were sobbing, we were. [Susie]

Some women were surprised on discovering their pregnancies as they had ceased to menstruate. Some also thought that their partners' fertility was affected by drug use. Concerns about the impact of drug use on hormones, ovulation, sperm quality and ability to have intercourse were discussed in interviews and focus groups. During one discussion, a woman suggested that drug-using men were less fertile than non-drug-using men.

I was only with Damien two months and I got pregnant. I was with this other fellow seven years, fuck's sake! [Focus Group Participant]

Some women were shocked because they had not planned to become pregnant while using drugs and because their partners or families did not know about their drug use. Recognising the *'definite taboo'*[81] associated with drug use and pregnancy, many would have preferred not to be using drugs and pregnant. Others were shocked because they had not planned to become pregnant at that point in their lives regardless of drug use. Some were very happy about the pregnancy and mentioned *'love'* or *'being into'* a partner as the reason for happiness. As Helen said,

I was delighted! I really was. I was so much in love with him and all this shit you know.

However, Helen had fears about whether she could cope. Seeing other pregnant women brought back memories.

I remember that one meself! ... "I'm not gonna be able to cope with a baby". I really thought "Oh I'm not ... going to be able to look after a child that's going to depend on me".

Second and subsequent pregnancies were sometimes welcome, other times unwelcome depending on the women's circumstances in terms of drug use, drug treatment, the age and stage of development of their other children, their relationship status, their health and the views and opinions of those around them.

In terms of those making the transition to motherhood for the first or indeed for a further pregnancy, many made drug use decisions as soon as their pregnancy became a reality. This tendency to stop drug use or to continue use, but to reduce use and implement harm reduction measures has been observed in many other qualitative studies (Boyd, 1999; Flavin, 2002; Klee *et al.*, 1998; Mahan, 1996; Mayock, 2003; Murphy & Rosenbaum, 1999; Rosenbaum & Irwin, 2000; Sterk, 1999a; Taylor, 1993). Women talked about *'snapping out of it', 'waking up', 'seeing sense'* when they discovered their pregnancies, generally referring to their drug use. As one worker described the situation:

When women get pregnant I watch their struggle because the first thing that they decide to do is to come down off their methadone when they find out they're pregnant. ... You couldn't have your child addicted you know. [Community Worker, W 06]

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[81] Nurse, W 07

Some found it difficult to stop using initially or stabilise drug use, a small number even increasing their use at points, as has been observed elsewhere (Carten, 1996; Goode, 1994). Twenty (76.92%) of the 26 women used illicit drugs initially or intermittently on one or more pregnancies. While the lack of sensitive, non-punitive treatment programmes may account for the higher rates of drug use during pregnancy reported in several studies carried out in the US (Maher, 1997), many women stopped their drug use, decreased their use or accessed treatment when they found that they were pregnant. Without a doubt, the women's lives were affected by this transition and their drug taking was also impacted upon. Almost all the women altered their patterns of drug use during pregnancy. Some became drug free, others stabilised on methadone maintenance programmes while some continued to use drugs, but used less and attempted to do so more safely.

Drug use appeared to be the only prevention concern during the women's pregnancies, despite the fact that alcohol use, smoking and the women's diet and nutrition often left a lot to be desired. This myopic focus on drug use may have serious repercussions. The women believed that in order to perform as well-behaved and compliant pregnant women it was crucial to reduce or cease using illicit street drugs. Significantly, some women thought that use of alcohol, a licit rather than illicit drug, was safe or at least considerably safer than illicit drug use. They believed that less danger is associated with the use of licit drugs. The illicit nature of heroin and the moral panic about drug use generally had led to misinformation or misconceptions about the risks of alcohol use, which highlights the concerns of those who have noted the 'all down to drugs' focus discussed in the literature review (Flavin, 2002; Hepburn, 1996; Rosenbaum & Irwin, 2000).

Twenty-five of the 26 women (96.15%) either used street drugs or were in receipt of substitute opiates during at least one pregnancy. One woman gave birth to her two children and completed her childbearing before ever using drugs. Twenty women (76.92%) used street drugs during at least one pregnancy. Five (19.23%) were on methadone maintenance before pregnancy, used no street drugs while pregnant and several reduced their methadone intake until after the births of their children. For three women, this was their first and only pregnancy to date, while a fourth woman had a pregnancy before she used drugs and one while on treatment. One woman was maintained on methadone during five pregnancies.

Several women continued to use throughout the pregnancy, often operating a variety of harm reduction strategies such as decreasing their intake, coming off tablets, drinking less alcohol and eating well. Nineteen (25%) such pregnancies out of the total of 76 were reported, five which did not go to full-term, two resulting in still births and three in miscarriages. Fourteen babies were born to the women, five of whom mentioned that their babies experienced withdrawals.

Sixteen pregnancies (21.05%), two of which were terminated, occurred while women were maintained throughout on methadone treatment. Fourteen babies were born to the women, five of whom mentioned the experience of withdrawals. Eighteen pregnancies (23.68%) occurred where

the women were initially using street drugs and then accessed methadone maintenance when they became aware of their pregnancies. Two babies were born alive but died in the hours or days after birth. Two pregnancies ended in miscarriage. Six women also reported their new babies' experiences of withdrawals. Four pregnancies (5.26%), one of which ended in miscarriage, commenced with the women using drugs and deciding to stop use completely. Nineteen pregnancies (25%) involved no drug use whatsoever.

Therefore 57 (75%) of the pregnancies could be loosely described as drug-involved, either impacted upon by drug use throughout, by methadone maintenance or by initial use and subsequent abstinence. Of the 53 pregnancies that involved opiate use or treatment throughout, there were 44 live births. Sixteen babies (36.36%) were reported by the women to subsequently display symptoms, described as *'withdrawals'* by the women and most of the professional workers and *'Neonatal Abstinence Syndrome'* or *'NAS'* by several professional workers, usually nursing or medical staff. In the first year of the drug liaison service, established in Dublin in March 1999, 112 babies were born to 111 women. 42 (37.5%) of these neonates had symptoms of neonatal withdrawals such as being *'hard to feed', 'twitchy', 'high pitched cry'* and *'loose stool'*. Twenty of the 42 babies were treated with substitute drugs (personal communication).

Considering the taboos about drug use during pregnancy and the guilt, shame and regret that many women experience in relation to it, this study gathered detailed information about the women's pregnancies, their drug use, treatment and harm reduction practices throughout the pregnancies and their babies' withdrawals after birth. Other studies have acknowledged the difficulties of accessing such data. In Rosenbaum's study of 100 women (1981a: 94), 70 of whom were mothers, only two who had children while using drugs acknowledged ongoing drug use during pregnancy. This led Rosenbaum to question the reliability of the women's accounts with regard to their pregnancies. However, in common with this research project, Maher's study of 45 women (1997: 32) identified considerably higher levels of drug taking during pregnancy than that of Rosenbaum's, reporting that 27 of the 36 mothers had given birth to a total of 57 children (59% of all children) while using drugs.

While using illicit drugs sometimes occurred during pregnancy, they all discussed the concerns, *'constant worry'* and *'guilt for the whole nine months'* harboured about the development of the foetus, drug exposure and the possibility of withdrawals, sometimes marring an otherwise joyful pregnancy.

> *I was riddled with guilt, you know. "The baby's going to be sick" and this, that and I listened to myths on the street and people telling me "Oh God! The child!" The baby came out. Not a bother on him!* [Helen]

These fears, worries, concerns and guilt had a significant impact. The majority sought to make changes in their drug use while pregnant. Many using drugs sought treatment and attempted to

stabilise their use. Others on methadone had concerns about level of methadone being prescribed for them and attempted to *'come down'* to lower doses.

The assumption that pregnancy is a time where women become or attempt to become drug free is interesting. Women talked about how they denied and minimised their use during pregnancy sometimes through fear, the threat of being judged as an *'unfit mother'*, fear of judgements, the stigma, discrimination, rough treatment or that their children might be taken into care. This fear seemed to have been much greater for older women.

> *I lied basically. I lied. I knew if I told them that I had had a hit or was using the odd one there would be serious repercussions. And again that was always the fear that they would take the children away from me.* [Liz]

Several young women were more confident than their older counterparts and asserted very positively that under no circumstances would anyone or any agency take away their children.

Undoubtedly anticipating birth and motherhood created anxieties for the women. *'Normal everyday'* concerns about having a new baby and making that *'real'* transition to womanhood existed alongside other concerns particular to women drug users. Their concerns about their fitness to parent or at least others' perceptions of their fitness to parent, their mothers' reactions and the impact of drug use on their foetuses or babies were central to their accounts. They confirmed that pregnancy is a both a stressful or motivating period often resulting in drug use.

Many regarded a *'good'* pregnant woman or a *'good'* mother as one, who decreases, preferably ceases, her use of drugs and avoids *'self-medication'*. So despite the constant assertion by workers that drug use *per se* does not indicate unfit parenting, there was an acceptance that their use should decrease or at least they should be maintained on methadone. Many women held similar views. Rosenbaum (1981a: 94) also suggested that the women participants regarded drug use during pregnancy as 'not acceptable' and viewed women who continued use with 'contempt'.

There were constant mixed messages about good and bad mothers and pregnant women. The drug use/pregnancy taboo was raised again and again. Several workers argued that these messages are internalised by women drug users. Helen described her baby as *'lucky'* because she did not consume either street drugs or tablets when she was pregnant. Professional workers also discussed the existence of these prejudices and attitudes, the *'huge moral vilification of the pregnant drug user'* [Social Worker, W 01], among women drug users.

> *We had somebody who was pregnant at the time who was being maintained and the attitude of some of the others because they had been drug-free when they were actually pregnant was like, they were actually quite judgmental some of the time with others. ...* [Addiction Counsellor, W 16]

However, despite assertions from some that women drug users and the drug-using community generally judge the pregnant drug user, others mentioned the support provided and how women were encouraged and acknowledged during their pregnancies.[82]

> *I think some of the most passionate moments I've seen is when you see a woman who is pregnant. When she discovers she's pregnant and she's absolutely delighted and she conveys that to other women who might be using drugs and that's a moment of joy. They go through it with her ... "How are you?" "How are you doing?" "How long have you got?" All of that, what you'd normally see, no different from what you'd normally expect.* [Addiction Counsellor/Manager, W 08]

Some professional workers responded in a manner similar to that of the external world. Echoing many women's accounts, several workers described the negative professional responses they have witnessed towards pregnant women drug users.

> *Some of the women felt that recognition wasn't given to the fact that - OK they're drug users, OK they're carrying this virus ... but that the pregnancy might have been wanted, that they might be looking forward to the birth of their child. For a lot of the women it was very difficult for pregnancy to be a positive experience because of all the negative labels associated with it.* [Social Worker, W 09]

Many professionals reportedly believed that 'good' women drug users should decrease their drug use and minimise the harm. Others believed that they should cease using drugs altogether in order to achieve this status. Others again believed that a 'good' mother or a 'good' pregnant woman should seek treatment from recognised treatment providers. They should cease to self-medicate and instead be in receipt of opiate substitution, prescribed by doctors. In addition, they should also submit to HIV testing, Hepatitis C and B tests, urinalysis and abstain from breastfeeding. Others argued that they should breastfeed despite the fact that some are separated from their babies initially after birth. Many women also held these popular views. Hepburn (1996) has discussed the view that all difficulties arise as a result of drug use and has attempted to challenge those myths.

Sometimes the women's knowledge of the risks associated with drug use in pregnancy was inaccurate. Often they believed that being prescribed methadone prevented their babies having withdrawals and despite adhering rigidly to prescribed regimes, their babies experienced withdrawals. Indeed most women smoked cigarettes through their pregnancies. Others thought street drug use was detrimental yet believed that alcohol use would not harm the baby.

> *At least I'm only drinking, I'm on methadone. I'm not using street drugs.* [Fieldwork contact]

While it appears that the majority of the first and further pregnancies were unplanned, they were welcomed immediately in most cases and in some very shortly after discovery. Once pregnant, women rarely considered any option other than to keep and raise their children. The majority of

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[82] This was frequently observed and often mentioned. There were moments where disputes arose if someone said anything negative about women with regard to pregnancy and parenting.

pregnancies were most definitely wanted. In this study ambivalence, while rare, arose for a variety of reasons. Often it occurred because of others' negative reactions to the pregnancy or the women's fear of rejection or abandonment by partner or family. Fears of revealing the pregnancy to families in view of the taboos about drug use and pregnancy were mentioned throughout, while fears of interactions with maternity services predominated in the accounts. Fears of the impending birth, of the treatment anticipated, and overwhelmingly about the possible loss of their children to the care of others concerned the women. Some fears were indeed realised. Counterproductive outcomes sometimes arose as a result of the 'defensive compensation' (Murphy, 1992; Sterk 1999a: 115) or strategies that they employed. For drug-using women, it is difficult to articulate fears or anxiety about their pregnancies and future ability and capacity to parent, as they believe that this will be constructed as evidence of lack of fitness to be parent. However, as for any pregnant woman, these are issues about being able to cope. Some described shock, others shame about an unplanned pregnancy.

> *I kept saying to myself, "Can I do this? Will I be good enough?" But I couldn't say that out loud.* [Sandra]

Alison attributed her ambivalence to her family's negative response.[83]

> *Happy? I was and I wasn't because I was getting like pressure off me sister and off me parents to either get an abortion or give the child up for adoption. But when they got used to the idea then they started getting excited. It was just a shock to them.*

By all accounts, ambivalence is the result of responses of family members, partners in some cases and services to the women's pregnancies.

Major concerns were expressed about the collision of pregnancy and drug use. The need for performance emerged once this transition occurred, as did the women's increasing visibility and vulnerability. Due to menstrual irregularities widely reported (Rosenbaum, 1981a; Deren, 1986; Sterk, 1999a; Taylor, 1993), initially many were surprised and shocked but generally pleased to be pregnant. While some studies noted women drug users' ambivalence about their pregnancies (Rosenbaum, 1981a; Taylor, 1993), the women only expressed ambivalence about their drug use, the impact on the foetus, feelings of inadequacy about the impending mothering role and fear of family reactions to their pregnancies. Consequently, for many, pregnancy often proved to be a stressful period.

Birth – Motherhood Attained and Welcomed

Before birth, the women were monitored by maternity hospital social workers, medical and nursing staff, drug liaison midwives and drug treatment personnel. Almost all the women talked at length

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[83] Alison discovered that she was pregnant three weeks before the Leaving Certificate Examination. She managed to sit the exams but described her performance and results as disappointing. It is also significant to note that her child resided with her mother and father as they had sought the formalisation of custody through the courts due to her drug use and against her will. They later did not accept her younger daughter who they have never met, largely as Alison said because they do not like her partner, the child' s father.

about their birth experiences. There was great diversity in the accounts proffered, some describing positive experiences while others described negative experiences. Several women endured what one maternity hospital social worker described as *'sad and bad'* experiences during pregnancy or birth. Some older women's accounts provided a portrait of service delivery that has, according to many reports, improved significantly.

A number of harrowing accounts suggested that being a drug user was perceived by the women to greatly affect their treatment at the hands of services. This has been reported in other studies (Boyd, 1999; Butler & Woods, 1992; Klee, 1997; Murphy & Rosenbaum, 1999; Rosenbaum, 1981a; Shea, 1992).

Katherine's traumatic experience of late miscarriage on her first pregnancy, while using drugs and methadone, left her grieving and confused and uninformed about what had happened to cause the loss. She described a difficult and painful experience during which she received little sympathy, attention or assistance from staff.

> *I've never experienced pain like it! And eventually I passed everything that night or whatever in the bed with the curtain around me into a bedpan. And this one said to me "do you want to see your baby?"... And I was left sitting on the chair in a little gown, I'll never forget it, on my bleedin' own! I'll never forget that feeling of oh of being so alone do you know and treated like shit!*

This experience represented a turning point for Katherine. She became drug free and has given birth to several children since that time. However during subsequent pregnancies and births, her history of drug use *'followed me everywhere'*. As a result of her details and records from the first pregnancy she related how her medical and social management was imposed throughout.

> *I wanted to do it right... They wouldn't let me breastfeed! ... "You can express milk for the next week till the results come back"... So I fed her with the bottle.... So when I was going down to the ward, she said "The paediatrician will be watching the baby". I said "For what?" "In case of withdrawals".... I sobbed. I'm telling you the truth! ... After the birth of the second child what they done different was sent the social worker up to me. ...But when she started, I started to panic. "They're going to take the bleedin' kids off me". I was clean but I went back to "Oh God, I'm doing something wrong".... Couldn't breastfeed the first baby. Social worker the second one, the paediatrician and they even said to me this time around "The paediatrician will be watchin' the baby". ... "Don't bleedin' start!" I said, "Paediatrician me arse!"*

Arlene's traumatic history of pregnancy and childbirth included a harrowing experience of giving birth in prison during the mid 1980s. Although told she experienced a miscarriage, she maintained adamantly that she gave birth to a pre-term baby and witnessed it being disposed of in a bin.

> *I had a baby in* (prison). *... I had a baby at seven months, at seven months when the baby started comin' out of me. ... I know the baby was born. I remember it was thrown in the bin. " Do you want us to help you?" I said "Yeah". "Well then stay quiet", you know like that. They pushed my head the other way.*

Katherine and Arlene's experiences resonated with the same sorts of difficulties described by several other women. When she discovered her third pregnancy at 33 years, Brenda reduced her

use. However she was put on a methadone maintenance programme due to the pressure, as she described it, from the medical staff and social work personnel in the maternity hospital. Although reluctant to take regular doses of methadone as she had reduced her drug use significantly, she finally acquiesced. She believed that the methadone affected the birth outcome. Several weeks later at approximately seven months gestation, her daughter was delivered by caesarian section. She lived for one hour.

> *I was just in total shock at this point and that was that! But to this day I feel that it was the methadone that killed the child. So we got an inquest done and everything. Nothing, it didn't tell me anything. But I know for a fact that child was fine before I started taking the methadone. ...They wouldn't believe me that I had cut down.*

The women believed that they were treated in a disapproving and punitive manner because they were drug users and pregnant. They also believed that their choices about interventions and care were severely limited because of their status as drug users. However, several witnessed their babies' respectful funeral services and burial, as did Elaine who gave birth to a stillborn baby at six months gestation.

> *It was awful to see him in his little white coffin and to see him go down. They were very kind to me in the hospital though. ... they let me talk about it for hours. The little funeral was beautiful, it was.*

Rachel related her experiences of pregnancy and birth during the eighties. Because of her partner's HIV status, she was segregated in a special ward along with another woman from her community who was HIV positive at the time. She described this experience as *'real degrading'*. Perhaps it is significant that Rachel delayed her attendance at hospital during labour on her last pregnancy and gave birth at home.

In the main, despite sometimes negative treatment experiences, the women welcomed motherhood. For some due to their drug use status, the baby's health or withdrawal status, motherhood was delayed after birth and babies were sometimes detained for as long as six weeks in paediatric units. In a few very rare cases of women met during fieldwork, motherhood was interrupted or terminated immediately.

Every woman described how giving birth changed her life. For some having ones own child and being a mother was important, while for others the increased responsibility was crucial.

> *Before I had my own baby I used to mind me sisters' kids all the time, do you know what I mean, from the time they were born I used to mind them mornin', noon an' night. I had them half the time. ... But when I had me baby I changed an awful lot, I did. It's mad, isn't it? ... I think I really became a real mother when I had her, I really did. ...I just can't let go. She's mine. She's my flesh and blood. ... It's just motherhood.* [Susie]

> *I'd taken so many drugs in my life over the years. ... But nothing got to me or got me high like her birth did... So it was very, kind of, so having her in my arms and feeling that responsibility. ... It was too overwhelming like.* [Ellen]

Those who used drugs or were methadone maintained while pregnant expressed fears about babies' withdrawals from opiates after birth. By no means all, but some women's babies experienced withdrawals as documented in several studies. In the drug liaison study carried out in Dublin, a higher methadone dose during pregnancy was associated with an increased risk of withdrawals in the babies (Scully *et al.*, 2004).

As mentioned earlier, in all 16 babies born to 13 of the 26 women experienced withdrawals. This was an often terrifying and upsetting experience for the women, some concealing their drug use from the medical personnel.

> *He was born three weeks early. I didn't tell them about the dope. ... and it was awful. He was like, he was on Phenobarbital, he was wired up and he was jittery. But I was afraid to tell them. ... I'm sure they knew.* [Liz]

Others, less afraid, were candid about their drug use and not afraid to ask for help for their children.

> *She was a bit jittery and and she wasn't herself, do you know what I mean? So I brought her back up and they brought her into the paediatric unit, that's the name of it isn't it ?* [Alison]

All of the women, whose babies experienced withdrawals, expressed feelings of guilt. They emphasised how they spent time with their babies in the special units, feeding and caring for them, trying to make up for what had happened and to prove that they were good mothers. Several workers also mentioned how this performance was watched and monitored. Several women were at pains to emphasise that they visited their children regularly each day for feeding and contact while the infants were being treated for neonatal abstinence syndrome. They believed that their abilities as mothers were being assessed during this period. This was confirmed by workers' accounts.

> *I was a good mother ...I went up to the hospital to see him and feed him morning, noon and night. So he was let come home with me.* [Laura]

Some described the suspicion and disapproval of staff and several experienced motherhood delayed as children were detained in hospital for social reasons. Significantly they highlighted some of the stigmatising experiences, such as the punitive attitudes and comments of staff; being left in isolation, *'segregation'* or in separate accommodation because they were drug users with or without HIV, infection control procedures; and their charts having yellow or red stickers (no one ever seems to be able to remember the colour!). One worker [W 05] described the experience of the *'average'* drug-using woman where *'the sticker denoting her drug-using past followed her from child to child, from baby to baby'*. Some women also mentioned occasions where they were left alone without care until all other patients were treated. Several reported being tested during pregnancy for HIV, Hepatitis C and Hepatitis B and several discovered that they were HIV positive or Hepatitis C positive during labour or sitting in a waiting room. Several experienced different infection control practices to the other patients, which they believed identified them as different and contaminated. As a nurse/midwife (W 33) suggested, these special practices such as segregation involved *'naming and shaming'* the women and *'isolating them even further'*. The workers

interviewed discussed these experiences at length.[84] Some, because of their direct involvement in the maternity services, gave detailed accounts of the sorts of issues arising, many emphasising how the situation was medically managed while psychosocial issues remained largely unaddressed.

> *With the drug-using population when they're pregnant there's all this work to make sure that everything is safe for the baby and once the baby is born then they withdraw, there isn't that same support.* [Nurse, W 35]

Other workers[85] highlighted specific circumstances pertaining to drug-using women who endured separation from their children after birth for medical reasons or withdrawals. The distance women must walk to see their babies and the *'empty cot or no cot'* beside beds all added *to 'compound the guilt'* (Midwife, W 33*)* and *'it was like the punishment being separated from your baby'* [Social Worker, W 09].

However despite occasional delays on babies leaving the hospital, a maternity hospital social worker (W 40) stated that the *'drug-using mum is vulnerable certainly but not really that risky'* as long as she is *'cooperative, compliant and acting appropriately'*. She added that 98% of the babies go home with their mothers, only two newborn babies a year going directly into care. However for those whose babies went immediately into care they usually had previous serious childcare difficulties, a long standing history of problems such as children already in care or with their family.

It is the start of a period where the women welcome both their children and their new status or confirmed status as mother. It ends the period of monitoring and watching the women during their pregnancies. However, it is also the period during which the watching and monitoring of their performance of mothering tasks and duties commences and where challenges to their motherhood status and role occur.

Birth has been described in the US as the 'dénouement' or 'the final showdown' for drug-using women, where often the women's involvement in parenting is prevented by the immediate intervention of Child Protective Services (Murphy & Rosenbaum, 1999: 102). More positively this Irish study demonstrates that their pregnancies and birth of their babies were welcome, valued and in the main, despite some challenges, were far from troubled experiences. Women often experienced problems and distress during the course of pregnancy and birth arising from interactions with the medical and nursing professions in the maternity system. However, in the main, birth experiences had transformative or reformative effects and were often described in terms suggesting epiphany or in respondents' words – *'redemption'* or *'restitution'*. Being watched and supervised by families became a major issue.

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[84] Discriminatory and stigmatising practices were discussed in almost every interview with women participants, while in-depth discussion of some of these issues occurred in several interviews with workers (W 01; W 02: W 04; W 05; W 06; W 07; W 08; W 09; W 10; W 12; W 18; W 19; W 20; W33; W40). Several workers talked about challenging the behaviour and the attitudes of staff in Maternity Hospitals (W 03; W 05; W 07; W 09; W 10; W 12; W 33; W 35; W 40).

[85] W 33; W 40

Interactions with Families – *'Not my daughter'*

Choices with regard to becoming mothers seemed to be more purposeful for women hailing from more affluent backgrounds. For those from inner-city areas, pregnancy and motherhood was a foregone conclusion. Indeed it has been suggested elsewhere that early parenthood may present a young woman with an opportunity to move into independent living and leave behind problematic family circumstances (Phoenix, 1990).

> *They're predominantly seen as being women only really when they've given birth and that's not again across the board but almost.* [Addiction Counsellor, W 02]

However, on becoming a mother, women realised that there was increased interest in their mothering performance and a new set of concerns ensued. The women's pregnancies and births often elicited a range of criticism from family members and the treatment providers they encountered. Many continued to live at least initially with their families of origin and apart from partners, their children's fathers, as found in other Irish studies of young lone mothers (Flanagan & Richardson, 1993; McCashin, 1996). This study also found that there were tensions where lone parents lived with their own parents, especially in situations where the families did not have many financial resources or were living in overcrowded conditions. Family relationships, particularly the women's relationships and interactions with their own mothers crucially impacted their experience of transition to motherhood and their experience of motherhood, somewhat echoing McCashin's (1996) findings. However while in my study the majority was not married and while they received lone parent payments, they often managed to live with their partners and co-parent. Therefore, they talked about *'getting the book'* but they rarely described themselves as lone mothers. Nonetheless, the reactions and responses of their mothers to them as mothers and to their children very much affected their experience of parenting.

Several families promptly took over the care of children after birth, believing the women to be *'unfit'* to parent. A number of participants suggested that families' disapproval of their drug-using daughters exceeded that meted out to their drug-using sons. This ignominy and difficulties were even greater where their daughters had children, as noted by several studies carried out in Dublin and elsewhere (Barnard, 2003; Duggan, 2007; Murphy-Lawless, 2002; Raine, 2001). It also highlights the gender socialisation and the importance for many women of being dutiful daughters, as found in another study of drug-using women (Friedman & Alicea, 2001: 103).

In her treatise's overview of the major life transitions among her study's young people, Mayock (2003: 205-206) mentioned the importance of their encounter with parenthood. She highlighted how several of her study's young women raised the issue of responsibility, the importance of being viewed as responsible, and the implications of being watched as 'users'. This was pervasive in my study of a more homogenous (at least in terms of drug taking) group of women, all of whom became problematic users.

The added sense of shame experienced by the drug-using daughters and their families, particularly mothers, was illustrated in many of the women's accounts and was reflected in turn in their concerns about their own children's potential future drug use. Professional workers and some mothers of adult women drug users met in the course of fieldwork also commented upon the strains experienced by families attempting to support their using member and deal with the shame and disapproval of neighbours. This often resulted in lessened support and increased isolation for the women.

> *So I think the natural kind of supportive network or like, the net that kind of supports families where there are young children, that can be strained - the grandparents, the sisters, the brothers and all that that tend to naturally be there to support anybody who has young children ...* [Social Worker, W 23]

Whereas 17 women had been the responsible *'little mothers'*, the less responsible girls were often cast as bad sisters.

> *I was the, always the messer and do you know, I'm not much, like and not much attention was put on me even though I was the youngest and people normally think that the youngest child is always spoiled and in my household it really wasn't the case.* [Alison]

As mentioned earlier, 20 (76.92%) of the 26 women were the only female drug users in their families. Only six (23.07%) women had sisters who were also users. Ten women (38.46%) in fact were the lone user in their families.

Sometimes the women's interactions with their families were affected by the fact that they had been using drugs, were former users or on treatment. Workers noted throughout that parents often withdrew support because of the women's lifestyles.[86] However there is no doubt that the majority of the women found their mothers and other family members supportive of themselves and their pregnancies. In many cases, families waited excitedly for the birth and the women recounted numerous stories about having to defend their motherhood status vis-à-vis their mothers' enthusiasm to raise their children for them. Several women's motherhood careers were delayed, withheld initially because they were regarded as immature and young mothers, and terminated ultimately because of drug use, in several cases their drug careers commencing *after* the loss of a child to others.

> *And like me Mam says, she says, "We're not taking him off you. But we're giving you the opportunity to go out and do what a teenager would do and we'll look after the baby. No problem". So I took up her offer and ever since, still up to this day, he's with me mother.* [Janet]

> *When they found out I was pregnant they didn't want to know. But as the pregnancy went on they started getting excited because there was only meself an' me sister and we were grown up. There was no other kids in the house and this was kind of a novelty. So I lived with me mother for a while and like me mother did do a lot for me because I hadn't really got a clue. But eventually when she did go to stay with me mother, like me mother went to court and got full custody of my daughter.* [Alison]

[86] W 01; W 02; W03; W 07; W 09.

Several women experienced motherhood terminated as the children went immediately to the care of their grandmothers.[87] Family support in this context can be counterproductive at some levels in the sense that it can create dependency and deny the woman her motherhood role. Often services look to extended families in the hope that relatives will step in. In a sense, this infantilisation of the new mother was often problematic.

> *And I think that's what's hard because I think again with drug-using women, that you know it's nearly seen in pregnancy "well who is in the extended family? Is there somebody available?" ever before the woman delivers. And there's that not even giving her the opportunity of seeing that maybe this pregnancy may be the big change in her life.* [Nurse, W 35]

Some respondents suggested that women might use or continue to use illicit drugs to self medicate and assist them in dealing with the stresses motherhood and parenting presents. Motherhood too was sometimes described as a possible *'therapeutic solution'* to the women's continuing drug use, the baby becoming the *'guardian'* for workers and others. Increased intervention by families and services and vigilance of the women is seemingly permitted when a baby comes into the picture. The women suggested that they are watched by parents, particularly their mothers and by services with more interest, care and concern when they become pregnant.

Having become drug users and mothers all believed that their families regarded them as *'irresponsible'* and *'unfit'*. Hence many felt that they were treated like children.

> *There's a lot of people telling me what to do* [Susie].

> *I feel treated like a child* [Janet].

Their accounts demonstrated understanding of some of the transgenerational trends and patterns that operated within their family systems. Several women had not told their mothers about their drug history, current use, their drug treatment or their HIV or Hepatitis C status. The women were sometimes reluctant to be open with their families because of possible judgements, fears that their mothers would *'kill'* them or fears that they would kill their mothers with this knowledge.[88]

> *But me mother died six years ago come November. ... I know I broke her heart. It was worse for her that I was a girl an' I was on drugs. Marion sometimes says I broke her heart. Charlene said one time she thinks I killed her.* [Sheila]

Some managed to successfully conceal their drug use for long periods from their families.

> *...there was people stopping her on the street and telling her and she kept saying "My Wendy! No! Not my daughter." So she asked me and I kept lying, lying, lying down to the ground.* [Wendy]

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[87] For Janet, then aged 15 years, and Alison, aged 17, this role was terminated because parents stepped in rapidly because of their youth and the fact that they were anxious to have replacement babies. Both women had not commenced drug careers at the time of pregnancy and birth, but interestingly started shortly after they lost the role. Darina was drug free after the birth of her son and remained so for almost a decade but her mother took on the task of rearing him. Emma's mother took over the care of two of her three children shortly after birth.

[88] These women were often the ones who were also reluctant to tell their children about their drug use and it appeared that they come from a background where not talking about it, hiding it and secrecy were common.

> *For a long time people were telling me Ma you know and she was in denial... Like "My Helen doesn't take drugs". I was selling drugs at the time!* [Helen]

Several women still concealed their illicit drug use and treatment from their mothers.

> *And for me to say I'm on methadone would cut her in half and I, her youngest, it would cut her in half.* [Jenny]

Fear of rejection often prevented women from telling their parents. Concerns about breaking their mother's hearts, incurring their mothers' disapproval or having their children *'taken'* by their mothers were all central issues raised. Others, despite insisting that their initiation into and continued drug use was not urged or encouraged by partners, suggested that their mothers blamed their partners for their drug use.[89] Women drug users' relationships with their families of origin are reportedly more difficult or problematic than those of their male counterparts.

> *A lot of male drug users can be actively using drugs and live at home but an awful lot of female drug users may be given one or two chances but then they're out... From my experience women drug users don't get the same chances and are viewed very differently and there seems to be harsher treatment of them within the family.* [Social Worker, W 01]

Parents seemed to believe that when their errant daughters had children *'their wings would be clipped'*. Emma believed that becoming a mother brought her back under the control of her mother, whose role she had taken over at an early age.

> *I remember when I had no kids and I was on drugs I used to be able to just get up and go. I wouldn't even say to my Ma I'm going here or I'm going there. I'd just go....But eh my ma said to me "As soon as you have that child" she said "your life is goin' to be all changed" and here I was "Yeah it will be changed"... But when I had her I felt it cause I just couldn't go anywhere, my life was changed, I was tied down, my freedom was gone from me. I was only eighteen. That was what it was like for me.*

Some professional workers also described this phenomenon.

> *The mothers almost have the upper hand by saying "you're pregnant. Go on then". You know so they're almost in control before they even deliver and there is this thing like your parents are pretty much always right.* [Nurse/Midwife, W 33]

Dependent on their mother's support, several feared their mothers' potential reactions to hearing about their drug use.

> *Like I could have told me Ma. But I was always afraid to tell. I was brought up with a fear as well, afraid to tell the truth. ... I'd say she'd give out to me, a woman with two children, a grown up. But I was just acting like a child, you know, thinking like a child, being a child. That's where I was at that time. At that time I wasn't in a good space in anyhow.* [Focus Group Participant]

Although several women's mothers were shoplifters, most women attempted to hide their involvement in criminal activities. Fearful of their mothers, they expended considerable energy concealing their sexual or drug-using activities. The sense of shame and stigma was strong and

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[89] Significantly, children of women drug users sometimes blamed their fathers for their mother's use as seen in the accounts of Andrea, Laura and Sharon.

hiding their deviant status was a preoccupation, some managing to successfully conceal their use throughout their drug use career. Their concerns moved from protecting the *'little mother'* status to protecting their roles as mothers, constantly trying to avoid the label of *'unfit'*.

Interestingly, and perhaps strangely enough, there are few mentions of male partners in terms of the women becoming mothers. While the women occasionally mentioned their partners, professionals rarely did. Some however drew attention to the conflict between the women's mothers and their partners, one midwife (W 33) describing how partners were often pushed out of the picture and marginalised. While one maternity hospital social worker (W 40) highlighted how the women may say little about their partners for fear of losing their lone mother entitlements, another (W 09) mentioned how she chastised male partners for their continued use of illicit drugs while their girlfriends were pregnant. Another doctor (W 12) mentioned how male partners are often excluded from treatment to the peril of the women. As noted, professionals often regarded women as victims of their male partners.

In discussion about becoming mothers, there was little mention of sexual activity during teenage years. Wanting to become a mother and becoming a mother was talked about as an anticipated event. However few talked about *'getting' the fella'* to facilitate this. Sometimes it almost appeared that the women were talking about immaculate conceptions! However, it is reasonable to suggest that these teenage pregnancies were important and significant events for the girls/young women and their families, particularly their mothers. Relationships with the fathers of their children were reportedly often discouraged by families and professional workers, although the women generally wanted their children to have contact with their fathers, as shall be seen in Chapters Five and Eight.

Romantic love was rarely mentioned in interviews, and when it was raised it was mentioned in passing. A few however mentioned *'being into a partner'*. These accounts were nearly all retrospective and few were currently involved in romantically and emotionally satisfying relationships. However, significantly while *'love'* emerged on a number of occasions and in a number of contexts and was mentioned by almost every woman on at least several occasions, they claimed that they did not often feel loved by their partners, reflecting the experiences of drug-using women elsewhere (Rosenbaum, 1981a, 1981c). When asked who cared for them or loved them, they identified their mothers and children as those who provided them with company, emotional support, affirmation and love.

Apprenticeship, Rehearsal, Becoming: Assessing the experiences

All accounts highlighted a number of key themes that weave their way repeatedly throughout the following study. Victimisation emerged as a theme during discussion of the childhood period, persisting throughout discussion of other periods such as drug use, pregnancy, parenting, interaction with services and loss of the motherhood role. Alternately survival, the hardiness and

resourcefulness of the women and their mothers were central to their accounts of childhood. These too were mirrored in the everyday experiences of their performance of mothering in adulthood against a background of poverty, domestic violence, childcare, control and gendered expectations. The women's lives and their mothers' earlier experiences of motherhood highlight a number of key themes such as performance, survival, control and resistance.

The women's acceptance of the inevitability and almost predestined nature of their trajectories through life is noteworthy. In terms of the vexed structure/agency debate emerging in the drugs and crime literature for some time (Maher, 1997; Mayock, 2003; Neale, 2002), it is interesting to note that many women's experiences were largely determined by the context in which they were reared and lived as teenagers. However, there was a concerted effort on the part of many to represent their lives as partially determined by their own autonomous choices. The tensions between structure and agency, cause and effect and 'victimage and volition' (Maher, 1997) were evident throughout their accounts. Sometimes women moved between different positions in highlighting and describing their experiences.

Despite the complexity, diversity, heterogeneity and individuality of these accounts, it is significant that key moments in the women's individual accounts of the journeys as drug-using mothers can be identified. The women reported experiencing much adversity and were witnesses to their families' experience of adversity also. The brunt of poverty and disadvantage was enormous. In only a minority of accounts were socio-economic hardship, financial issues and basic survival issues not mentioned or irrelevant to the women's experience as children. Unemployment, underemployment, the loss of previous income was mentioned as the women related their fathers' stories of being impacted on by changes in the local economy, particularly the docks in Dublin port.

They also witnessed their mothers' traditional and gendered performances as mothers, sometimes of very large families. Managing households and involvement in work outside of the home was regarded as normal for women. However, despite experiences of victimisation in childhood and later in their lives the women did not present in the main as victims. They emphasised their resistance, survival and hardiness. They viewed themselves as making choices particularly with regard to becoming involved in both drug use and motherhood.

In this chapter the women's experiences of what I describe as rehearsal or working through an apprenticeship for motherhood were related. For the women in this study, pregnancy, birth and motherhood mark where childhood ends and the transition to womanhood and adulthood occurs. For some, their early identification with motherhood began with acquiring responsibilities, parentification and the taking on of a 'little mother' status. Pregnancy and birth then represented actual physical transition to motherhood for those who have already made a psychological or even symbolic transition to such a role. The majority aspired to motherhood and many were vehemently

anti-abortion[90], anti-adoption and believed that women were *'born to be mothers'*. On the other hand, the women seemingly had never imagined they would be middle-class, full-time housewives. Women in inner-city areas have rarely been or had the luxury of being *'stay at home'* mothers, despite clauses in the Irish Constitution purporting to endeavour to protect them against being obliged by economic necessity to work outside of the home. The women have witnessed their mothers and grandmothers as they 'double shifted' or even treble shifted as mothers, workers and volunteers in their own community. They also highlight the transgenerational nature of their gendered experiences, their experiences as girls and women largely mirroring their mothers' experiences, except for the drug use experience.

On the basis of the findings presented in this chapter, it is reasonable to suggest that two transitions described, becoming a user and becoming a mother, are central to the women's accounts and the workers' observations. They recounted how they acquired new identities, statuses and, in most cases, roles as drug users and as mothers. One status, role and identity, that of motherhood, was a source of great joy, pride and a sense of achievement. The women regarded this involvement as success, achievement and adulthood. The other, that of drug user, brought about feelings of guilt and shame, leading to secrecy and isolation. Furthermore, all accounts suggest the strongly held conviction on the part of the women and workers alike that the women's motherhood careers and experiences are impacted upon by childhood experiences, their interactions with their families and how their families and communities perceive them.

The women had now become mothers. Their 'being' mothers is of course always guaranteed by virtue of having given birth. Notwithstanding this, their challenges in the 'doing' of mothering now began. The challenges of beginning a mothering career in such circumstances are evident. As we shall see, conversely, the women may always be guaranteed the identity and status of drug user, even when they have long ago stabilised on methadone or desisted from use entirely.

Conclusion

This chapter focused on the women's early life experiences. Varying accounts of relationships with parents, experiences of abuse and school attendance were offered. The adversity experienced by the women's mothers in caring for their households, children and partners was emphasised. Against this backdrop, several women's vulnerability, their experiences of violence or emotional distance from their mothers as children were observed. The majority of women had experienced violence as children. In addition, many professional workers reported that experiences of violence, parental involvement in alcohol use, childhood bereavement, loss and parent-child separation arose for a large number of women.

[90] Unlike in another study (Sterk, 1999a) where many women considered abortion, few women in this study contemplated such a course of action.

The women's experiences during childhood years, teenage years, introductions to drug use and transitions to motherhood introduced the account of drug-involved motherhood. In almost every account, the women began their life stories and accounts of experiences of motherhood through reference to their childhood years, their experiences of being parented and how they adopted a little mother role. Many women expressed their desire to parent their children differently to the manner in which they were reared and related their experiences of being parents to the experiences of having been parented. Many professional workers argued that the women's childhood experiences impacted on their parental ability, capacity and competence as adults. The gendered expectations of girls in childhood, teenage years and becoming an adult were evident in these accounts. Already confusion and questions arose about the differences between their mothers and fathers' experiences and between theirs and their brothers'. Their awareness of the added stigma or spoiled identity as girls who used drugs was heightened by family reactions to their wayward daughters. This was further accentuated on becoming mothers.

Despite fears, the women welcomed pregnancy and the birth of their children, embracing the motherhood role. However, initiation into established patterns of drug taking reportedly led to the postponement of their recognition by others as adult women, which motherhood should by all accounts have heralded. These formerly over-responsible young women now were infantilised, regarded as immature, irresponsible and 'unfit' for motherhood. The conflict between these two statuses, roles and identities, and merging of both so that they become drug-using mothers – *'junkie mothers'* – is the issue, which causes them most concern. This collision of roles, identities and statuses provides the focus of the next chapter which will examine the women's experiences as mothers at different stages of the drug-using career, managing and combining the dual careers in drug use and motherhood in the face of such opprobrium.

CHAPTER FIVE

MOTHERHOOD PERFORMED:

'TWICE AS GOOD TO BE HALF AS GOOD'

> Woman represents important symbols that are the bedrock of society. When angels fall, they fall disturbingly far. We would rather have them in their place, which is another way of saying that they define and make our place comfortable.
>
> (Curlee, 1969:171)

Chapter Four focused on the women's childhood, their drug initiation and transition to motherhood. Having made the transition their lives were busy and challenging, involved with parenting, drug use, household management, subsistence and survival. This chapter examines women's mothering experiences at different stages of the drug-using career, its impact on their lives as mothers and their drug use.

Several studies, many in the ethnographic tradition and mainly focusing on the male experience, illustrated how heroin users engage in activities such as accessing drugs and the money to pay for them (Agar, 1973; Parker *et al.*, 1988; Pearson, 1987; Zinberg, 1984). Some of these studies and others (Faupel, 1991; Friedman & Alicea, 2001; Mahan, 1996; Maher, 1997; Morgan & Joe, 1996, 1997; Preble & Casey, 1969; Rosenbaum, 1981a; Waterston, 1992, 1999) portrayed a process of inundation into the drug life sometimes to the exclusion of everything else, including partners, children, and families. However, only a small number of studies have examined women's careers as drug users, briefly visiting how careers in both drug use and motherhood are managed simultaneously (Rosenbaum, 1979, 1981a; Sterk, 1999a; Taylor, 1993, 1997). Several have considered women substance users' everyday experiences and views of mothering (Baker & Carson, 1999; Boyd, 1999; Goode, 1999; Hardesty & Black, 1999).

In this chapter, the women's experiences of being mothers and drug users, often perceived as mutually exclusive and contradictory categories are recounted. The women's accounts of mothering, co-parenting with partners and against a backdrop of poverty and stigma are described. Their views of parenting, expectations, and opinions of others' expectations of them are explored. Firstly, experiences of women drug users as mothers while using drugs, while on treatment and while drug free are related. Then the gender differences in parenting are discussed followed by a description of the backdrop of poverty and deprivation in the participants' lives. Finally, questions are raised about the combining and managing of the two careers.

Drug use and parenting

> *It's hard being a parent anyway. ... But when you're a drug user, you're up against so much more.* [Liz]

> *But women hold it together, even while using they hold life together. .... They have an agenda, which is duplicated when using drugs, and they still manage to hold life together. ...* [Addiction Counsellor, W 08]

Several studies described women drug users' experiences while using drugs (Maher, 1997; Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993). These also described how some women managed to handle drug use and motherhood identities although many of the women's children were in the care of others. Therefore, while we learn a little about the day-to-day experiences of managing the 'doing' of motherhood, the focus has been on the women's general concerns about motherhood among many others. By contrast, in this study 21 women (80.76%) experienced parenting at some stage while pursuing an active drug-using career. Childcare and parenting while using drugs was a major challenge described as *'the biggest catch 22'*. Some managed to combine drug use and parenting, often with family and partner support. Other women managed both careers with their mothers' support. Some did it alone periodically. However, as will be seen later, some lost their mothering role after long-term attempts to maintain both careers failed.

All those interviewed were mothers although not all were currently caring for their children.[91] Of the 205 contacted, 193 were mothers of 442 children and foster mothers of a further seven. The 26 women interviewed had 64 children and two women were also caring for four foster children. Seventeen women (65.38%) interviewed experienced parenting at every stage of a drug-using career. Three women (11.53%) had parented both while using street drugs and drug free and had never parented on methadone. Four (15.38%) had parented while maintained on methadone, one (3.84%) as an active user, and one (3.84%) while drug free.[92] Some combined careers in drug use and mothering successfully for long periods of time without others even becoming aware of their drug use. Some managed both careers for a period but were less successful in maintaining both in the long-term. Some said that whereas it was *'easier in some respects'* to parent when drug free, it was not necessarily *'better'* than when they were using or on methadone. Others suggested their drug-free parenting was *'of a better quality'*. While for some, things fell apart quickly when using drugs, others maintained the role independent of their drug status.

Women attempted to manage the two careers, parenting while using drugs, dealing with the presence or absence of partner and family support, encountering housing difficulties and interacting with services.

> *I think for women drug users, they have to manage that little bit more. It seems to me that they need a lot more energy to expend in order to keep taking care of that whole business whether it's taking care of children, bills, food a whole range of things and on top of that manage what I see as punitive system which*

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[91] See Appendix VII - The Women's Chidren and Care Arrangements
[92] See Appendix VIII – Parenting & Drug-Using Status

they have to go into in terms of their own drug use. They've to manage all that and they've to listen to people who are sometimes very well paid telling them what to do and how to operate. Sure they're managing all of this and managing to carry on in drug treatment. They're managing to hold it all together you know. [Addiction Counsellor, W 08]

Furthermore, not only did they balance the careers but they also contended with people's reactions to them as drug-using mothers. Professional workers also were aware of the women's responsibilities while using drugs.

It's incredible what they have to get through in a day. They have to raise the money for their drug use and a lot of the time for a partner's use if he's around. They shoplift and then worry about getting caught and they often are apprehended and imprisoned. Then it's a case of "What will happen to the kids?" They have to spend their afternoons visiting partners in prison, bringing the kids and the drugs in. [Medical Practitioner, W 30]

By all accounts, women worked hard to meet their children's needs and expectations. Almost every worker interviewed, including those with the gravest concerns about drug-using mothers and their parenting performance, highlighted how hard the women worked to make things good for their children even while engaged with heroin use.

The women talked about the importance of a number of key principles which they claimed underlay all their attempts to *'keep the show on the road'* – *'the children came first'*, *'holding it together'*, *'keeping the drug use and the kids separate'* and *'hiding it away'*. As one of the professional worker participants stated:

Nobody is telling the positive stories of women who actively are addicted but who can keep things together, ticking over. [Community Worker, W 34]

The children 'came first'

The women generally recalled how their children's needs would be seen to before drug use took place, asserting that in their view their children *'came first'*, echoing several accounts in other locations (Klee, 1998; Rosenbaum, 1979, 1981a; Taylor, 1993). Many women, while mainly preferring the drug free or *'clean'* identity to that of drug user and expressing feelings of inadequacy about their drug user status, strongly asserted that their parenting had been adequate and their children their priority while they used drugs.

I do think that I do give a lot and I do think that I put them as my number one priority and I do think that I always have done even in the midst of my drug use. And I think that in the chaos and the shit that went down and all that I do think that Sally was top on my priority list. [Ellen]

Several women, including several now drug free, highlighted this in their accounts, maintaining that there was little difference between parenting before, during use or while being treated.

I never stopped that role for a second. No, the kids never ran short for anything. If I left my barrier down for one second I know something would fall out of place. ... So I couldn't let that happen 'cause at the time I didn't want nobody to know I was taking drugs ... I was still the same person looking after my kids. [Ethna]

This somewhat challenges other findings about the perceptions and memories of drug users, now in recovery whose reminiscences about their parenting involvement and capacity were overwhelmingly negative (McIntosh & McKeganey, 2002; McKeganey *et al.*, 2002). Involvement in drug taking has been viewed as the primary concern of women using drugs, all other activities regarded as secondary or burdensome (Friedman & Alicea, 2001; Klee, 2002a, 2002b; Sommers *et al.*, 2000; Sterk, 1999a). This notion of children coming first is challenged by several accounts of professionals interacting with mothers, family members and of parents themselves (Adams, 1999; Barnard, 2003; McKeganey *et al.*, 2002; Scourfield, 2001, 2003).

While an understanding of their children's dependence on them for their needs for food, clothing, shelter and education was evident, a defensive undertone, however, about letting barriers or guards down was often present, again a phenomenon observed elsewhere (Murphy, 1992; Murphy & Rosenbaum, 1999; Sterk, 1999a). The women's accounts often focused on the availability and distribution of financial and material resources between their children's needs and their drug use.

> *We were strung out. ... They had to come first. They were the first thing on the agenda, you filled the fridge and the presses for the week and whatever was left then ...went on whatever.* [Sharon]

> *Always the kids came first. That was it, like. If he only had £20 on him, and there was no bread or anythin', it'd go on the bread or whatever. He'd just go sick. You can't leave the kids without nothin'. They only have me and him and we know what it's like.* [Marina]

At the same time an understanding of agenda, routine, keeping things going seemed to be present.

> *But in regards to living life and like as much as practical stuff, it'd be perfectly normal to get them kids to school ... Like you'll always make sure when you're in the drug culture that they're fed, even if it is coming from the café, they'll be fed.* [Andrea]

Often women parented and used drugs for quite lengthy periods before anyone became aware of their use.[93] One woman and her partner cared for her son while they used drugs and ran a business. Significantly, she problematised her working career outside of the home rather than her drug use, which she claimed made her a better parent.

> *In another way that was the gear that slowed me down enough to be a good parent. I'm actually a far better mother on gear than I was when I was a worker...Cause I started staying at home.* [Brenda]

Several others also argued that their parenting was better when they were using drugs. While many doubts occurred about being *'part of that scene'* which eventually led to her becoming drug free, one woman contrasted her positive experience of caring for her first baby while on heroin with her anxious experience of caring for her second while drug-free.

> *I was so uptight with my youngest, Rachel in comparison. ... I remember playing Barbie with Sally for hours and playing games with her for hours, you know and all of that you know. Sally was with me all the time yeah. But at the*

[93] In a small number of situations I met individuals who had used, parented and never accessed services.

same time, thinking about it, at that time being a part of that scene, I think I was actually OK. [Ellen]

The children coming first despite drug use was mentioned constantly by the vast majority of women. While their attempts to put children first were recognised by a large number of the professional workers also, not all were so sure. This was a place where conflicting accounts emerged as seen throughout.

> *Well they say they look after their kids and they do in a way. But sometimes it's just the material things and the emotional needs get overlooked.* [Addiction Counsellor, W 36]

In addition to workers' concerns, Katherine, who became a mother after becoming drug free, problematised drug use and parenting. She represented a minority view throughout in discussing other women's mothering performance.

> *Well they meet their kids' needs, clothing wise, anyway, keepin' up with the Jones', the shoppin' all that. ... Or they might, they'd feed them or whatever. But apart from that I think the good that they do is undermined by the fact that all they witness, all they experience, the Jekyll and Hyde of bein' there one minute and fuckin' screamin' at them the next minute.* [Katherine]

These accounts were both confirmed and challenged by accounts offered by professional workers in the field, some believing that all drug-using mothers fail to put their children first, others suggesting that some do and some do not. None argued that all the women put the children first. Indeed many women recounted that the juggling acts they performed meant that different things were prioritised at different moments. As one woman stated:

> *The heroin has us working 24/7. ... Heroin, money, cleaning, kids, you never sit down.* [Emma]

At moments, indeed, heroin, money and cleaning came before the children. However, the women talked about how they aspired to put their children first in the scheme of things, even where they may have ultimately failed to do so. It seems that there is a divergence in the views held by the some of the professional workers about the mothering performance and those expressed by the women themselves. Those working in drug treatment tended to express mixed views.

Co-parenting

Partners of women drug users are rarely mentioned in the literature as co-parents. Many studies have noted men's involvement in women's initiation into drug use or the impact they have on women's drug taking, as noted earlier (Ettorre, 1992; Grella & Joshi, 1999; Maher, 1995a; Rosenbaum, 1981a, 1981b; Sargent, 1992; Sterk, 1999a; Taylor, 1993). Some of these studies, alongside others, have critiqued and challenged these limited views of partner impact on drug use (Klee, 1996, 1997; Maher, 1995a; Taylor, 1993). Others have noted the marked absence of the women's partners in their accounts of parenting (Baker & Carson, 1999; Friedman & Alicea, 2001; Rosenbaum, 1981a, 1981b, 1981c). Interviewing both men and women drug users, Klee (1998) reported how couples involved in parenting were able to share the tasks of parenting and other

studies (Klee *et al.*, 2002; Klee & Wright, 1999) highlighted the benefits of a supportive partner. In this study, the women acknowledged and discussed the role of their partners in co-parenting, managing the two careers and in raising household and drug funds. The involvement of partners often crucially determined whether a woman drug user's life as mother was more or less manageable.

> *If they have children and they haven't got a partner, it's horrific. Because they have to do everything, they have to try and score their gear, they end up in trouble with the law because the only way they can sustain any sort of lifestyle is if they shoplift ... More of them, I think, now are getting involved in prostitution.* [Nurse, W 07]

Some co-parented and divided labour with their partners, five women (19.23%) describing their partners as those who *'do everything'* on the domestic front while also involved in childcare. Six women (23.07%) described their partners as involved in childcare but not in the *'women's work'*. However 15 women (57.69%) described their partners as *'doing nothing for themselves'* in the household. Some partners were themselves disruptive.

> *I remember there's times when I had to, I remember living with me partner, there was no food, no milk, I'd have to rob and bastard, and being out straight he was a bastard at times, he sat there and let me go and do all I done. I don't know how I'm still with him.* [Emma]

> *I was never lucky enough to have a partner that was on drugs and carried me on them.* [Fieldwork contact]

However, without exception all wanted their children to have fathers present in their lives, feeling like they have failed if they had not. On the other hand, some workers believed that partners were often unsupportive, caused *'more harm than good'* and made extreme demands on the women, which sometimes took attention away from their children.

> *Partners aren't usually supportive. More unusually. They don't usually, most of the partners, I think and I try not to generalise too much. ...while they're supportive, it only goes so far and it's conditional. They're often supportive in one place and not in another. The men are the power in the relationship and the women do the work. They're very traditional, the relationships, yeah they would be.* [Professional Worker – Focus Group 3]

> *Men on the other hand are reduced very much when they start using drugs. They can do nothing only give out and pressurise their partners into taking care of them.* [Addiction Counsellor, W 08]

Others described their partners as supportive and helpful, involved in doing all the drugs work and sharing the parenting. Some women divided the labour of parenting and drugs work with their partners, sometimes sharing or alternating the roles.

> *Well when I'd get up I'd have a "turn on"[94]. And I'd get the kids up, wash them and dress them, you know, a normal day, give them their dinner, give them their tea, time to go to bed. And he used to take the little ones down to his ma's, the two of them, and I'd have a turn-on while he was gone. And then when he'd come back I'd take the kids out and he'd have one then. That's the way we worked it. And the nighttime we'd use together because the kids would be in bed, you know that way ...It's hard lookin' after two kids and we used to take*

[94] Inject drugs

turns... Sometimes we wouldn't take heroin. We'd take Phy[95] *as well, you know, not only heroin, you know.* [Marina]

With several notable exceptions, however, almost all the women described a situation where when they were present, the men left parenting to them. Some women managed to *'keep things going'* with or without partners. Many women were those who *'do it all'* at home in addition to looking after their own drug needs and sometimes their partners. They sought their own drugs, often bringing their children with them.

> *It is different for men because ... Like if they're still with the mother of the children, like they don't really have part of it. All they're thinkin' is "well I want half of the heroin what she gets" and that's it. Other than that they don't care about the children or the mother. In a way they're usin' them 'cause I know a lot of fellas who use their girlfriends just for heroin, to have heroin.* [Janet]

Others (seven women) described how they waited at home for partners to go robbing and return with money or drugs.

> *You're left sitting at home like waiting and he's gone missin' hours and hours an' like you're sick, like you're in bits you are, and you have the kids and you're startin' to roar at them and you're watchin' the clock. And when he comes back he's stoned.* [Focus group Participant]

Partners were also generally waited upon and expected to be waited upon. As many as 15 women described numerous incidents of *'serving'* the men, providing a range of supports, physical, emotional, drugs, *'drops'* to them in prison.

> *Because women are supposedly the ones that are the housekeepers and look after he children and the men are supposedly to go to work and come in and have their dinner on the table and their slippers waiting and ... Well that's what my partner thinks anyway, even though he doesn't work! He thinks that these things should be done for him.* [Alison]

Others waited for imprisoned partners to be released and return to their families and role of fatherhood. Nevertheless men were much less involved, if at all, in the day-to-day practical work of nurturance and daily care.

> *The whole thing about the responsibility of children is absolutely given to the woman – the fathers rarely play any part in the picture...It's almost as if they're not expected to.* [Social Worker, W 01]

> *Not that the adult males don't take an interest or responsibility for the children, often they do, but where there's separation or break-up, very often the children end up with the women, so the women share more of that responsibility, and we see quite a bit of that of the women who are struggling to keep their family together.* [Medical Practitioner, W 29]

According to professional workers, many women drug users were

> *doing the divil and all. Everybody else came first, the kids, the partner, whatever else and that they were kind of down the list.* [Nurse, W 07]

> *Because if there was a partner involved, the partner wouldn't be bothering his arse doing anything, you know what I mean. ... although I've seen a couple of*

[95] Physeptone – synthetic opiate used for substitution in Dublin before changing over to methadone.

> *men who were in my estimation evidently shit hot when it came to looking after the kids, like you know. Men in general detach whether they're drug users or not.* [Addiction Counsellor, W 08]

The women also mentioned, as did several professional workers, that their experiences as drug-using mothers and their male counterparts' experiences as fathers were impacted upon in different ways by drug use. Different and gendered responses by treatment providers and social workers to women as mothers, while ignoring men's roles as fathers, were also noted. Again Ellen observed,

> *That's the way our society is, I mean, I don't think though the same discrimination goes against men if they're a parent you know. "Look at her, she's on drugs and she's a mother" or "She's pregnant and she shouldn't be". Like you don't say "He's a drug user and he's a father". ... But you'd hear people saying "she's a junkie and she's a mother", you know, that's what you'd hear.*

It was argued by many that the stigma experienced by women was greater highlighting the gender differences identified in a range of studies (Barnard & McKeganey, 2004; Boyd, 1999; Clarke, 1994; Friedman & Alicea, 2001; Hogan, 1998; Kearney, 1994). Indeed this is where similarities exist between drug-using and non-drug-using women as it is recognised that parenting is constructed as the preserve of women (Gillies, 2006; McMahon, 1995), multiple roles are the reality for all women (Hochschild, 1990; Klee, 2002d; Taylor, 1993) and women generally are regarded by society and services as almost exclusively responsible for children and their protection and welfare (Buckley, 1998a, 1998b, 2003; Scourfield, 2001, 2003). In later chapters, gendered social work practice will also be discussed.

'Holding it together' and *'Keeping the careers separate'*

However with or without partners many women combined the careers, talking of *'functioning'* and *'keeping it together'*. Several women avoided medical treatment services, successfully concealing their use and resisting the stereotypical *'junkie'* label.

> *So I never really thought I had a problem because I always got the kids to school and I often worked, do you know. ... And I had a good social life.* [Frances]

> *I went with Pat for treatment and he was the one with the problem, you know. I had no problem! I was real together and even when I was an injecting drug user, I wasn't a "junkie" or anything like that, do you know what I mean? I was still holding, as far as I was concerned, things very well together. And I was in ways because nobody knew really whether I was using or not.* [Ellen]

These attempts at maintaining a certain order and staying away from treatment services have been identified before among Dublin based women drug users (Butler & Woods, 1992; Dunne, 1995; Farrell, 2001; Nangle Connor, 2000; Shea, 1992; Woods, 1992, 1994), and are not exclusive to them as women's fears and concerns about involvement in treatment and its impact on their mothering involvement have been observed in other locations (Copeland, 1997, 1998; Copeland & Hall, 1992; Copeland *et al.,* 1993; Friedman & Alicea, 1995, 1999, 2001; Grella & Joshi, 1999; Lewis *et al.*, 1995; Reed, 1985; Rosenbaum, 1981a; Sterk, 1999a; Swift *et al.*, 1996; Taylor, 1993).

The vast majority of women described how they attempted to function, remain invisible – *'off the radar'* - and keep their two careers separate echoing the accounts of women in other studies (Kearney *et al.*, 1994; Murphy, 1992; Rosenbaum, 1979; 1981a; Taylor, 1993). Their drug use and parenting were either kept entirely separate or else the women pursued certain strategies to provide protection to their children (Barnard & Barlow, 2003; Hogan & Higgins, 2001b; Kroll & Taylor, 2003; Richter & Bammer, 2000; Rosenbaum, 1981a; Taylor, 1993). Where the activities might be kept separate, the influence of many things contributed to difficulties to keep the worlds apart, especially in situations where children were taken out to score drugs or where drugs were brought to and used in the home.

All the women claimed to have attempted to ensure that their children witnessed as little disruption as possible. While this was not always feasible, most maintained that their children never saw them taking heroin, either smoking or injecting. Several however acknowledged that sometimes this was beyond their control, as seen in other studies (Hogan & Higgins, 2001b), where their children suddenly entered the room while they were taking drugs.

> *Sometimes it was a complete horror scene! When I was using I always tried to shut the kitchen door and shut the kids out, not let them see what I was doing. I'd never let them see me. You know I wouldn't sit and use in front of them. But they always knew something was going on when the door shut, you know. And that's the part they didn't like. "Mammy shut the door". "What's going on in there?" So they were old enough to know now.* [Laura]

Several women regularly mentioned *'covering the tracks'* of their partners, to ensure that the children did not see their fathers using drugs. In order to ensure this, they often took drugs before children got up in the morning, when they had left for school, when another adult was caring for them or when they had gone to bed at night. The women usually planned ahead and had a supply in place for the following morning.

> *Some mornings I'd have my heroin there.* [Darina]

Sometimes, however, they had to purchase drugs and use before their children woke up. Lacking a supply in the morning was the worst thing imaginable, impacting on the organisation of the day and the tasks and chores required to keep their households going. Once the supply was guaranteed the women felt that they could meet their obligations and responsibilities.

> *It was ok when you had your gear and you were just normal, like not sick or anything.* [Susie]

> *And if you're a heroin user and you're getting' heroin constantly all the time and it's not a major ordeal for you to get it that would be fine.* [Ellen]

Life became more difficult when the supply was low or they had no heroin to hand and sometimes then routines broke down.

> *I had my two kids, one was two and one was a few weeks old. I used to get up at eight o'clock and I always made sure I had me money for my gear that's the way I'd have it. And if I hadn't got that, Jesus Christ, it was horrible! Me brothers would look after me but some mornings they weren't always there for me, do you know what I mean? When I think back, it's horrible, it is for any girl*

that has kids that's out there using. You end up very dependent on others. [Focus Group Participant]

There was bad mornings when there was no money and no heroin! You just had to go sick! Dying sick! [Amy]

Above all, the women attempted to ensure that their households were managed during their drug use. However most did not realise how difficult management of the two careers and survival was until they started treatment programmes. Then realisation dawned.

It's very fuckin' hard to keep your habit, to try to hold down a family, hold a family, hold a house going. [Alison]

It was also described as difficult to keep all these things compartmentalised. Even where these activities were limited or non-existent, their interactions with others also affected their abilities to keep the careers separate. In the minds of family, communities, drug treatment providers and social work services, the careers were inextricably related. While using drugs the women avoided being challenged in their mothering role and described a defensive parenting style throughout. Women, now drug free or drug free lengthy periods, also outlined this phenomenon. However, of the five mothers using street drugs throughout the research period, three were no longer caring for any of their children and one was caring for two of her three children. Only one woman's motherhood role had not been yet challenged. Two women used periodically during the period, having lost their children into care. Being subjected to control, monitoring and surveillance generally and within the treatment and child welfare contexts is raised a lot throughout the literature and is argued to be more an issue for drug-using women generally, and for drug-using mothers specifically (Friedman & Alicea, 2001: 109). Fears of asking for help of family or treatment providers were present, as observed elsewhere (Taylor, 1993). Despite this, continued drug use seemed ultimately to impact considerably on the women's opportunities to care for their children. Understandably then, even where women balanced the two careers successfully, they still claimed that their lives and their children's lives were better when they were methadone maintained or drug free.

Making Changes – Parenting on methadone

But when I started having me kids I never touched any drugs. [Rachel]

And like all week, I'm on the go cleaning, doing whatever has to be done, I like to live like a normal person that's not on drugs. That's the way my life is today. [Emma]

Methadone maintenance provided some women with an opportunity to stabilise their street drug use and, in some cases where it was threatened or lost, lead to a preserving or a restoration of the motherhood role. Many studies have examined the parenting practices of women on methadone, the health and welfare of their children and their social support (Bauman & Dougherty, 1983; Bernstein *et al.*, 1984; Burns *et al.*, 1996; Colten, 1982; el-Bassel, Cooper *et al.*, 1998; el-Bassel *et al.*, 1998; Hogan & Higgins, 2001a; Wilson & Wait, 1981). Some have identified differences in

parenting practices between those maintained on methadone and non-drug-using women while others have identified little difference. In the main these studies have looked at practices rather than the social construction of the methadone maintained mother. However, Banwell, (2003) focused on the converging discourses about methadone mothers, an identity that significantly was referred to by women in this study on many occasions during interviews, focus groups and street fieldwork.

Of those interviewed, 21 women (80.76%) parented *'on methadone'* at some stage. Those who had also parented while using drugs described how they maintained both careers and compared or contrasted the two experiences. However the women in this study, while they viewed their performance while using drugs as motivation to become drug free or methadone maintained, were disappointed to find that they were now *'methadone mothers'* and had to combine mothering with attending a clinic and being a patient on a daily basis, an experience further elaborated upon in Chapter Six.

Many women, similar to those in other studies (Grella & Joshi, 1999; Taylor, 1993), described their fears about asking for treatment and support, believing that they would then be regarded as *'junkies'* and *'bad mothers'*. Simultaneously they often felt there was little choice and for many women the motivation for seeking treatment was to protect their children and meet their children's needs, as noted elsewhere (Barnard & Barlow, 2003; Hogan & Higgins, 2001a; Klee *et al.,* 1998; Kroll & Taylor, 2003; Richter & Bammer, 2000; Rosenbaum, 1981a; Taylor, 1993). Many women in this study also identified their movements to treatment as being for their mothers' sakes too, highlighting the importance of their mothers in their lives. Their concerns about harmful potential impacts of drug use on their children propelled them towards treatment services, to *'make an effort'*, seek methadone or become drug free. When the supply was low, a partner was imprisoned or circumstances changed, maintaining both activities became difficult and routines broke down.
It was then that many sought help, attended a treatment programme and the *'Phy is there for you every morning'*. Visits to the clinic and a new routine began. Several women and workers described this routine as a reprieve from the *'busy-ness'* of drug use, while others identified this new regime as busy in a different way.

> *They've to make it on time to their treatment programmes, look after the kids, get them to school, get them out. All these things, they're real struggles and some are more or less successful at coping with that multiplicity.* [Community Drug Worker, W 38]

Initially, some enjoyed the more relaxed routine of methadone maintenance and spending time with their children and caring for their homes.

> *When I went on methadone and I couldn't understand the time I had on my hands because I didn't have to go out and rob, do you know what I mean?* [Emma]

Brenda contrasted life using drugs with that on methadone and regarded having more time with her child as a positive outcome of this more relaxed way of life.

Oh hectic, hectic, very hectic! My God! It's great now actually that we're on the methadone, you know, Jesus we feel that the day is so long....It's very time consuming (when we were using). I'd loads of time for Harry especially with the methadone because you're not even out scoring. You're living a very together life and yet you're calm and very, you've loads of time and you enjoy little things.

Liz, the mother of teenagers, lacked the luxury of methadone maintenance when her children were small. She maintained that, if using illicit drugs, a steady supply of heroin or treatment with methadone permits commitment to and involvement in parenting and the establishment of routine and consistency in family life. The lifestyle associated with drug use such as involvement in criminal activity, prostitution, seeking and purchasing drugs all undermined and affected her life with her children. She wondered if things might have been different for her and her motherhood role had she been treated at that stage.

With the kids being small it would be a priority to me that they were safe and that they would get the nappies changed and their bottles and I knew I couldn't be out of my bin ...At one stage I had phenomenal amounts of gear. But I only wanted just enough to like feel nice. I hadn't a needle fixation. I didn't want to shoot up six, eight times a day. If I had a steady supply, twice a day was grand. A bit like I'm on this ridiculous amount of methadone now – it's a tiny measure.

While some described little difference between their daytime activities while using and their day on methadone, others highlighted the difference and the extra vigilance from families. The women generally described their lives in terms of their childcare responsibilities.

Oh I had to go straight home from the clinic cause the kids was in school. Or else maybe one of them was a baby and me Ma'd have her and she'd say, "You be back, straight back.... You be back to mind those kids. You be back for them kids". [Rachel]

I just go to my course in the mornings. I go home. I collect me son from school, the eldest fella. I bring him home, take his uniform off, change him into clothes for him to go out and play. Then while I do the ironing and that, I just have a cup of tea and wait for the other fella to come... When he comes, I go down to me clinic then and then we probably go on a walk or go down to me Mam's sister or we go on a walk uptown or something like that, cause he's a child that hates being in the house. He loves to go out and play. [Janet]

I had me methadone and I was in me little flat and I believe me parenting was OK ... I was able to go out and get the kids to school ... I was just getting me methadone and I'd go into me little course and me parenting was getting really good. I felt me relationships with the kids, I was getting closer to them ...[Andrea]

However the *'honeymoon period'* did not happen or even last for everybody and many talked about the time passing slowly – *'the time I have on my hands'*. In a sense they have lost one of their occupations, either work or crime, ensuring that they have enough money for drugs.

I've always said that if somebody has been a drug user and then you hand them methadone, it's like you've made them redundant...because they had a bloody good job before that! [Nurse, W 24]

> *You can get methadone from now until the day you die and the lethargy that I've seen move into people's lives is destructive and it doesn't allow people to move on.* [Addiction Counsellor, W 02]

This issue of redundancy was also identified among women in Taylor's study (1993). As a result many expressed feelings of uselessness and mentioned their lack of self worth. Some also mentioned that when they gave up the use of street drugs and the activities associated with raising funds for their use, they had less disposable income for their children and partners, also observed in other studies (Hogan & Higgins, 2001a; Sterk, 1999a). Interestingly many continued to raise funds in the way they always had, with all the associated risks of arrest and imprisonment, except that now these funds were more often directed towards their own self-care, that of their children, partners and homes.

> *I shoplifted to support me habit and then when I had me kids I shoplifted for them because the money, you just cannot live on it, no matter what ... everything for them, every holiday and all, what I was used to getting, I wanted to give me kids better. But I definitely wouldn't be able to do time now, not with me kids.* [Rachel]

> *Even if they managed to get stable on their drug use, they've so many rent arrears, they've so many, so much electricity arrears and so much that they owe the debt collectors because of their daughter was going for their First Holy Cmmunion and you cannot appear at a communion without her looking like a little bride, that those kind of issues make any kind of stability almost impossible.* [Social Worker, W 03]

Others identified how the women were as busy as ever *'running here and running there'* when in treatment. The women were still *'busy, busy'* managing their interactions with services.

> *Parents with drug problems probably would need diaries the size of, I don't know, volumes to try and fit in all the things that they have to do... It's a very busy life!. ...I just think that the diary for people with drug problems who are parents as well is really very complex.* [Social Worker, W 40]

Several women in receipt of methadone now worked in various capacities, three working as peer support workers in drug or HIV services.

While some women contrasted the *'busy-ness'* of the heroin life with the more relaxed and regular life after receiving methadone maintenance, workers particularly stressed how a new pressures had taken over and that women were now busy engaging with a range of drug treatment, community welfare, health and social work services. Also evident was the lack of consistency in the experiences described. *'Honeymoon periods'* on heroin and methadone were variously described, but it appeared that maintaining this managed lifestyle in the long-term was a real challenge to many women. Boredom, less money, less contact with friends and social networks, less support in some cases and greater expectations on the part of family and community were factors described by many which seemed to render the methadone experience unique and impact in some cases and to some extent on stability. Also evident in the accounts was the fact that many regarded the methadone experience as little more than *'officially recognised addiction'* so that the associated stigma persisted.

Some women spoke of methadone as a saviour of sorts, saying - *'I just take my methadone'*, *'I'm on the clinic'*, *'I'm only on Phy now'*. They had reformed, redeemed themselves and left street drugs behind. Several talked contentedly about *'being a normal mother now'* while others viewed methadone as a *'stopgap'* or a stage on the way to becoming drug free. Several women spoke as if past involvement in illicit drug use must inevitably deprive them of the right to mother and the opportunity to be a *'proper mother'* as opposed to a *'drug mother'*. They often viewed methadone maintenance negatively, betraying their negative views when they said things such as *'I'm on methadone but no matter what I care for my child'*. Jenny, while describing her treatment in a maternity hospital said that they treated her very well *'even though I was on methadone'*. They also were concerned about their children's potential discrimination or stigmatisation as the children of drug-using parents or of *'Methadone Mas'*. One Addiction Counsellor (W 18) observed that many women were *'even ashamed to be on methadone because for them that's a drug too'*.

The issue of shame and methadone arose on a regular basis. Some of the women were very pleased and proud to have achieved what they saw as stability in their lives as a result of accessing a methadone maintenance programme and they said in the main that *'I did it for my Ma'* or *'I did it for my kids'*. Some stated that they could not take life on the street combined with parenting anymore. However others wanted to *'come off'* methadone as quickly as possible, to get away from the control of the clinic, the humiliation of being urine tested several times weekly and particularly did not want their children to witness them receiving treatment. Several women used the term *'Methadone Ma'* or *'Methadone Mom'*, maintaining that their partners, their parents and people in their communities often used this desultory term. Several were concerned that they were now just *'methadone junkies'*.

> *I'm not a fuckin' drug user. I take 30 mls of Phy, that's all and I'm more stable now than I ever was you know.* [Helen]

Some focus group participants described how several workers during a discussion of the pros and cons of methadone maintenance at a conference held in Dublin, had described them as *'Methadonians'*.[96]

> *It sounded like we're from outer space, aliens like. One of them thought he was really clever and funny calling us that!*

So the belief that many held about *'being clean and just on my Phy'*, *'trying to lead a more responsible life'* through stabilisation was often negated by these images of *'not being clean'*, *'being addicted'*, *'methadone mums'* (Focus Group 3), *'methadone mas'* (Ethna) and *'methadonians'* (Focus Group 2). Some professional workers also referred to this labelling. Recent descriptions of women on methadone as 'harm minimized mums' (Reid & Hodson, 2005), yet another label, exemplifies this. Several women's *'overnight'* decisions to detoxify from methadone at a point in

[96] This term, 'Methadonians', was used in the title of a book describing a social worker's brief period working in a methadone clinic that she named 'Methadonia' (Baldino, 2000) and also in the title of an article dealing with users' perspectives (Montagne, 2002).

their lives where they were perhaps most vulnerable and at risk were evidence of this counterproductive effect and were perhaps very understandable reactions.

While several professional workers believed that some people on methadone are *'zombies'*, *'methadonians'* or *'not addressing their addiction'*, many women believed that they have achieved a great deal and were *'making an effort'* in stabilising on methadone, on *'coming clean'*. Many accessed treatment for a variety of reasons, including increasing difficulties maintaining the role as mother, imprisonment of partners or pressure from family, community or services. The majority attributed their decisions *'to clean up and do something with my life'* to the importance of their children and their parenting role. The women themselves sometimes expressed negative views of those on methadone.

Conflicting views and knowledge about methadone among workers and women alike were intersting and deserve mention here. While it has been noted that methadone has increasingly been constructed as the 'mother's drug' (Hollis, 1998), the opiate-using mothers' little helper, allowing for stabilisation and ongoing monitoring, simultaneously several drug treatment providers and social workers expressed derision and disapproval of methadone maintenance as a viable option. Several drug treatment workers raised the mixed social work response to drug-using and methadone maintained mothers, particularly noting several social workers' disapproval of and punitive practice with methadone maintained mothers. This suggests that despite their attempts at stabilisation the women are still viewed as 'methadone mothers', 'deviant' or less than 'good' or 'proper' mothers, also noted elsewhere (Banwell, 2003; Friedman & Alicea, 2001). Several studies of social workers' and other professionals' attitudes demonstrated that many workers have little knowledge about methadone and often view it as addictive and merely a substitute for heroin (Adams, 1999; Klee *et al.*, 1998).

Perhaps it is interesting to note that several women lost custody of their children while receiving treatment. Others had lost custody while using drugs and on accessing treatment did not succeed in being reunited with their children as they had hoped. Many women in this situation found it difficult to maintain the stability they had sought and relapse was common.

Making Changes - *'Cleaning up'* and parenting

> *I've come a long way from where I was. .... Still I say to myself sometimes "I can't do this. I can't cope alone", doubting myself as a mother. I'd have to say, I try to be the best parent and I am!* [Katherine]

The challenges of rebuilding their lives after exiting from the treatment system were also described by participants. Some of these experiences of reclaiming a normal life and motherhood status after a career in drug use echo several studies among women in this stage (Carten, 1996; Kearney, 1996). Becoming drug free did not necessarily impact on the women's confidence or indeed their mothering opportunities, as evidenced by the experiences of several women, who quickly returned

to drug use and drug treatment. In terms of *'cleaning up', 'getting recovery'* or becoming drug-free, some made the transition through detoxification or maintenance on methadone and were linked to the clinic-based services. Others stopped using, employing 'talking therapies' to achieve and maintain a drug free life. In total, 21 women (80.76%) have parented at points in their careers where they were drug free, some before they commenced using drugs, but most at several points during their drug-using careers and several after their drug-using careers had ended. Many women were drug free and parenting for lengthy periods during their careers in parenting although at interview they were using or on treatment. Coming off and going back on drugs has been identified as a common experience among drug users (Friedman & Alicea, 2001; Klee, 2002d; Parker *et al.*, 1988; Pearson *et al.*, 1987; Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993; Waldorf, 1973; Waldorf *et al.,* 1991). The varied fortunes of the women with regard to detoxification, rehabilitation and relapse confirm this.

Unlike the women in another study of drug-using women, none of whom managed to give up their drug use (Sterk, 1999a), several women managed to give up drugs for often lengthy periods of time and some managed to remain drug free. While 21 women, a large majority, had spent periods of time parenting while not using drugs, five women were drug-free former users at the time of the research, all of them more than three years and four of them describing themselves as *'in recovery'*. While inability to hold it all together and inability to cope were the several dominant reasons offered for trying to *'clean up'* or become drug free, the most often stated reason was the women's children and the necessity to *'see the light'* and start being a *'proper mother'*.

> *Then, I don't know, we started selling hash and we started selling heroin and then it just went really mad.... So I knew that I'd just reached the end of as far as I was prepared to go. ... I was being fuckin' sucked into more and more crime. I'd reached the stage in my life where I just couldn't cope any longer. She was my number one priority.* [Ellen]

Four (80%) of the five drug-free women had parented while using drugs, while one woman had lost a pregnancy while using but did not become a mother until after her drug use ceased. All five women have all their children in their care, although one experienced an interruption to her motherhood career while she was using drugs. It is interesting also to note that two women, Ellen and Frances, ceased use without medical intervention, while Andrea decided one day to cease taking methadone. Katherine underwent a brief detoxification in hospital, while Amy slowly detoxified herself with methadone purchased on the street. Their lack of dependence on the medical treatment system was notable and mirrors the experiences of some who have left the treatment system and 'matured out' of drug use without interventions (Biernacki, 1986; Miller, 2002; Miller & Rollnick, 2002; Winick, 1962).

Becoming drug free, however, *'wasn't all plain sailing'* and brought new challenges. For those whose children were in the care of others, attempts to be reunited were paramount. Several women, who had been drug free for long periods, did not succeed in defending or maintaining their parenting role. Several became drug free in order to attempt reunification with their children but

were unsuccessful and relapsed. Two women, Ethna and Sharon, currently non-custodial mothers, had stopped attending the clinic detoxifying from methadone without assistance, but relapsed and returned to their methadone programmes. Becoming drug free did not change either of their situations with their children. They believed that although social workers promoted the notion of being drug free and *'off everything'*, they still preferred that they remained as patients of clinics, where monitoring and surveillance was possible. Despite their efforts, they both remained *'methadone moms'* and non-custodial mothers.

However, for those who resided with and cared for their children, the long hard task of making up to children and reestablishing lost roles constituted struggles. Parenting roles changed and were often challenged after becoming drug free.[97]

> *Well I suppose I was mentally more aware and I was more there for them. I mean there was this whole thing in the family, a big power struggle in the family when I was taking back my role as a mother. Because my eldest daughter had become the mother and she was doing all, she was the little mother....and looking after the younger kids and looking after them really well of course, do you know.* [Frances]

Even where women had not parented while using drugs, reconciling themselves with their past created challenges.

> *It's the most important thing I'm going to do in my life and I have to tell you it's the fuckin' hardest because no matter what I do I always feel I fall short. I never think what I do is good enough... But I want so much for my kids to bleedin' get what I didn't get, to break that cycle once and for all. But I want so much, to want it sometimes that it's almost painful, do you know what I mean?* [Katherine]

They had interesting insights to offer about women drug users and parenting, ranging from one woman's total disapproval of either drug use or treatment with methadone while parenting to outright challenges of society's views by others. The women pointed out how guilt is endemic and how the lens through which parenting is examined imposes certain views. Frances described how she *'avoided being a mother'* because of her experience of sexual abuse as a child, while describing the tendency to feel worse on coming clean.

> *When you clean up, people make you feel worse. You went around telling yourself what a bad mother you used to be when you used drink, when you drank. .. and I went to meetings for many years and I said what a crap mother I was and talked about things that I'd done....I think I was a good mother in some ways....I think when I stopped using and got the opportunity I became a really good mother, you know. So it's a different way of seeing the world really isn't from through the lens of guilt to a certain extent as well.*

Andrea echoed her words adding:

> *I found in early recovery that was the toughest time in parenting 'cause I'd found I had so much of trouble at this time, wanting to do the right thing and there's a bit of a perfectionist in me and I was kind of guilty. There's guilt from my past, from active addiction and I felt "Oh I'm going to give, give, give, give, give!" and*

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[97] In discussion with several adult children of women drug users, this issue arose. One young woman, who had been the 'little mother', described her anger at her mother's return to her role of authoritative mother.

I learned that that's not the way. And I had to learn hard that you know I had to separate different kinds of feelings of guilt and then find out as a parent what is the role of the parent.

Whereas many women believed that they could impact on their children and *'guide them along the right path*', some did not have that sense of power, as will be seen later.

However while *'coming clean'* was regarded as the ideal outcome and as the way that a woman could be guaranteed to maintain and preserve her mothering role, at the same time even when women became drug free some social workers were still concerned.

I've seen parents who've gone through treatment and have totally stopped taking drugs and for me that doesn't necessarily mean they make good parents at all. And in fact, there's you know, that we as social workers say to parents "Right you've got to stop taking drugs. You've got to go in for treatment and then you can have your children back". For me, that doesn't really equal that at all because I don't think using drugs in itself necessarily means that you can't parent your children. But I also don't think just because you've stopped taking drugs doesn't mean that you can. So taking away the fact that they're not using drugs anymore doesn't mean that they can mind their kids because all their other problems can still be there, like low self esteem, like getting abused as kids, like separating from their own parents. [Social Worker, W 37]

This begs the question about whether it is the drug use *per se* or a range of familial, contextual and psychological issues that are central. This difficulty with separating out the range of issues and identifying the unique effects or impacts of substance use on parenting has also been raised in other studies (Barnard & McKeganey, 2004; Hogan, 1998; Hogan & Higgins, 2001a; Kandel, 1990). Perhaps it is also interesting to note that all five women who are drug free and parenting remain 'dual career' women, a phenomenon identified elsewhere (Taylor, 1993). Four of the five have attended university, achieving a degree in one case and undergraduate diplomas in three others. All five women worked, three in drug agencies.

Many argued throughout that drug use and motherhood are not mutually exclusive activities. Examining the various stages of the drug-using career and the women's experiences of mothering has demonstrated the heterogeneity of the women's experiences. Some women experienced negative responses to their mothering performance, often depending on the extent of inundation in drug-using activities.

Even within the drug-using community, there are in my experience, different social groups if you like that operate in different ways, and in some social circles it would be an absolute no no to in any way shoot up with your children present or even for your children to know that you were a drug user would not be kosher, but whereas in other families, it is openly done. And there's no secret. The children are possibly even used in the purchasing or whatever. [Social Worker, W 23]

However, many managed to maintain and keep separate both activities without ever attracting the attention of others, let alone be regarded as unfit to parent.

Not all women drug users are unfit parents. I mean I don't know what way most women are living their lives but I know most of them put their children first. Don't get me wrong, you get the odd one that probably wouldn't give a shit

about their child and would throw him from Jack to Billy and Billy to Jack or whatever. But most women drug parents or drug users would look after their kids and put their children first, definitely. ... [Darina]

The women's accounts of their experiences of motherhood extended from well before their first pregnancies to their children reaching the age of majority in some cases or where their parenting careers have ended in others. A focus on the average day experience of mothering at different stages of their drug use and parenting careers offered interesting insights into their parenting, drug use and the division of labour with partners. It also highlighted their gendered experiences generally and their experiences of poverty and social and economic disadvantage, the subjects of the following two sections.

Mothering and Drug Use – Traditional and Gendered Expectations

The literature review highlighted how drug-using women and particularly mothers are regarded as deviating from the norm with regard to traditionally appropriate roles and characteristics. The women espoused relatively traditional views of gender roles, as seen in other studies (Baker & Carson, 1999; Friedman & Alicea, 2001; Rosenbaum, 1981a, 1981b; Taylor, 1993). Throughout, a focus on gender difference was maintained even though the study focuses only on women's experiences of parenting. It appears evident from this study, as it has from others (Rosenbaum, 1981a, 1981b; Taylor, 1993), that the differences between men and women's experiences as parenting drug users were often most evident in the unequal division of labour with regard to both drug use and parenting, in the need for women to *'juggle'* and manage everything. There was a gendered expectation among male and female users that where women use drugs, they will combine both careers, serving and caring for their children and partners. It was rare indeed that women were even supported by partners. There was an overwhelming view that there are differing gendered expectations for girls and women with regard to child bearing, rearing and childcare. These are different for all women but particularly gendered and traditional for all young Dublin working-class women, whether drug-using or not.

Most respondents regarded drug use and its associated lifestyle as presenting different opportunities and difficulties to men and women, asserting that societal expectations of men and women were highly gendered.

It is a man's world anyway isn't it so they think. Men can do what they like. There's no equality at all. ... [Darina]

I think life is less fairer for women than for men. I think men have it an awful lot handier in every aspect. Thank God I have a son! [Helen]

Interestingly several of the 11 male professional worker participants spoke at length about the gendered nature of women's experiences generally, the gendered nature of women drug users' experiences specifically and one pointed out that he could never adequately understand the experience because he was male.

> *Maybe I sometimes struggled with some of your questions because I'm not as fully aware of the needs and that's because I'm male and I don't always see it, I see the world from a male viewpoint.* [Social Worker, W 03]

On the other hand, while many of the women professional worker respondents believed that they could understand the experiences precisely because they were women, others more realistically noted the socio-economic, educational and other differences between the vast majority of workers and those who use the services provided by the same workers. It was agreed that women's experience of drug use was qualitatively different to that of men.

> *I do think that their experience is different [from men's]. But I'm not sure that that's because they're drug users. I think it's because they're women....I think that the differences then can be drawn from the fact that already women in those communities are not on an equal footing with men.* [Addiction Counsellor, W 02]

There was also an overwhelming consensus among women and workers that the experience of drug-using mothers is a '*whole different ballgame*' and differed distinctly from their childless female counterparts.

> *With a child it's different ... you've got to make sure they're fed and that, it's not just in the pram and out!* [Focus group participant]

> *Kids or no kids, that's a huge difference. I think if they have children, they find it extremely difficult.* [Nurse, W 07]

The underlying assumption that women should bear the full responsibility for parenting and child care was ever present and expressed by many professional workers, who themselves had experienced the benefits of child care, for which they paid, while they worked. These assumptions about women drug users' parenting roles render them similar to other women in Irish society, who are affected by the lack of childcare provision generally and who, if they do access childcare, must purchase it.[98] This was raised by both women and workers and echoes some of the issues with regard to childcare discussed in Chapter One. In fact almost every woman raised this concern. As Ellen pointedly remarked,

> *But then the system hasn't geared treatment around women, you know. Like* (named residential agency) *thirty years on they haven't got crèche facilities for women. Thirty fuckin' years on! And they want women to go into rehab like! And to give their children up!...if they're lucky to a family member! If they're not*

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[98] In an edition of *Brass Munkie* (December 2006: 10), a meeting between UISCE (Union for Improved Services, Communication and Education), a users' support organisation and the HSE run City Clinic in the North Inner City was reviewed. It reported that 'the whole area of childcare is so expensive, under resourced and not given the priority it deserves. The policy at City Clinic is that children should not be brought to the clinic if at all possible due to the nature of the service. They do not provide childcare facilities for two reasons:
1) it is not their responsibility to provide childcare
2) the building does not lend itself to having a childcare facility.
They previously had a room where service users could leave their children while they got their methadone or saw the doctor/counsellor/nurse. This service could not continue because the facility did not meet with health and safety standards. In the future they hope to buy places in private crèches in the locality. The reps also told us that they hoped to move City Clinic to better premises in the future. We asked them to put the childcare issue on the agenda if they were to secure better premises. When they had the childcare on occasions children were left there after the parent left the building and reluctantly they had to call social services. So providing this service comes with all sorts of demands.'

> *so lucky ...and if they don't have a family member who's going to take the child? You're talking about voluntary care, do you know what I mean? And then how do they go about getting their kids back out of that when they decide to become clean? So like nothing's really, really changed at all really, has it? ... If people are going to set up treatment centres, they should have crèche facilities and that women can actually bring their children into treatment with them, that they work through their treatment with their children, you know.*

Throughout this chapter, and indeed in this study, an attempt is made to highlight the women's experiences of providing for their children and rearing and supporting them into adulthood. The notion or process of performance, both performance of gender appropriate or feminine roles and the mothering role, in order to achieve the approval of others during pregnancy and while parenting dominated all accounts. How did or do they 'perform' to be accepted by a myriad of groups such as their drug-using counterparts, their counterparts in treatment, their children, their partners, their families? How did or do women drug users 'perform' for the services? Most importantly, how was their parenting performance assessed? How was one assessed as a 'good' woman drug user and 'fit' mother? In the eyes of many women and workers, successful and adequate performance of these roles often equated survival. Their performances were rarely unobserved and they always had to prove themselves, *'parenting in public'* with a *'public eye on that'*. While performance was expected in the 'straight' worlds of family, community and drug treatment services, drug users' expectations of women drug users to perform as mothers were reportedly also high, echoing other studies (Rosenbaum, 1981a; Taylor, 1993).

> *And you have to keep them all the different workers happy because if you don't keep them all happy somebody's going to draw a conclusion from it and it may be that there's other things going on as well with family and partners and what have you.* [Social Worker, W 40]

In fact it appears from their own and workers' accounts that a considerable number of the 193 mothers met in the course of the fieldwork were indeed either 'exceptional mothers' (Rosenbaum, 1981a: 97) or certainly had been exceptional in the management of the two careers and meeting myriad expectations for very long periods.

With regard to drug use and stability, performance was crucial too. Workers claimed that women were obliged to tell *'awful tales about how chronic, and how awful and how out of control their drug use is'* [Social Worker, W 01] in order to get a response from services. Telling appropriate stories, telling workers what they thought they needed to hear and providing urine samples for screening constituted performance, *'what they might have to do in order to get an ear even from a worker'* [Outreach Worker, W 10]. While this sounds humiliating, those who performed well often achieved what they needed from the system and were perceived by other users as having status.

Performing certain roles in accessing services and support was also described. One could reportedly perform as victim when necessary or as villain. While few described themselves as victims, they suggested that victim performance and status have value. Against the powerful backdrop of attitudes, stereotypes and images of women drug users, presenting oneself as a victim

may be a survival strategy in itself. It has been suggested that the women *'have to be in their own eyes whiter than white'* [Addiction Counsellor, W 08]. They often presented themselves as victims, minimising their use in order to protect themselves from punishments. Those who come in contact with women drug users, whether they are practitioners or researchers, occasionally minimise their 'deviant' status for the same reasons. The overall thrust of victimology may indeed be well intentioned and have clear protective functions, closely aligned as they are with performance and survival. However, victimisation was interpreted and presented in interesting, diverse and often harmful ways by workers. Others too have suggested this perplexing and disempowering outcome of victim approaches (Klee, 1996).

While the women outlined how services intervened in their lives, many professional workers were concerned about the extent of disadvantage and resulting powerlessness experienced by drug users as a client group.

> *Their lives are open books, and they feel they need to tell their story in order to get what they are genuinely entitled to.* [Childcare Worker, W 25]

> *I couldn't believe the openness of some of the women about their drug use. It shocked me that they met me and almost instantly their life was just on the table, in front of me.* [Community Worker, W 04]

Many believed that women offered personal information too readily and performed the learned helplessness role, which the *'voyeuristic'* treatment and social work services demanded. The women were always watched and monitored and they *'abbey acted'*, *'played the victim'* and *'played to the gallery'*, which included treatment providers, families, partners, children, social workers and community. Regarded as a learned strategy for survival, professional workers were impressed by their clients' ability to *'hustle'* their way through life.

On the basis of all accounts, nowhere was performance more pertinent than in commenting on the women's experience as mothers and the monitoring of that experience. Having told awful tales, sometimes greatly exaggerated in order to *'get something from services'*, their parenting performance then came into question and was open to challenge and scrutiny. In many cases, this performance was assessed from the moment a woman's pregnancy became public knowledge, as highlighted in Chapter Four. The collision of the two careers involved having to parent in public.

> *They have to prove themselves twice as good in a way that nobody else is judged because of the bias in perception.* [Community Worker, W 05]

> *I'd hate to be out there now with an addiction proving myself, parenting in public, proving myself in public, night, noon and morning.* [Community Worker, W 34]

This parenting *'under the microscope'* and *'heavy wattage'* necessitated that drug-using mothers endured a situation where *'their starting point is minus – minus forever'* [Drug worker, W 08]. Aware of the need to perform, almost all the women believed that they had to be better than non-

drug-using mothers because having simultaneous careers in mothering and drug use determined how they were perceived as mothers.

> *Drug-using women have to be extra good and extra careful and extra clean with their children, and keep their homes clean.* [Darina]

However they often did not know how to be *'better'* or what was expected of them as mothers. The issue of cleanliness and hygiene seemed to surface again and again. Perhaps being *'clean'* in ones home and having *'clean'* children was viewed as making up for not being *'clean'* drug wise. *'The image of the woman drug user and the baby in the buggy'* [Social Worker, W 01] or *'the woman drug user, a mother, lying in a lane somewhere with a syringe in her arm'* [Community Worker, W 04] connoted powerful images that seriously impacted on how women were viewed by the general public and professional workers.

It has been suggested that gender differences become more evident later in drug-using careers when the chaos, uncertainty and inundation affects women drug users' roles as mothers, impacting on their ability to keep it together (Rosenbaum, 1981a: 47). Nevertheless, this chapter reveals that many women managed both careers for lengthy periods. There is no doubt, however, that women's main stated reasons for accessing treatment and support were their children, their exhaustion with maintaining both careers and their self-disapproval. The disapproval of community and society towards them as drug-using mothers and, above all, the fear of losing their children to others or where they had already lost them, their fears of never retrieving or having their mothering role restored, were also identified as motivating factors for accessing treatment.

'Keeping the wolf from the fold' – managing poverty

> *The question is how do we manage to survive on what little money we get.* [Rachel]

Poverty featured large in the women's experience in both their accounts and those of the workers, as it has in several other studies of women drug users (Dumas, 1992; Friedman & Alicea, 2001; Goode, 1999; Taylor, 1993; Woodhouse, 1992) and parents and children (Barnard, 1999; Clarke, 1994; Cleaver *et al.*, 1999; Forrester & Harwin, 2006; Gilman, 2000; Grella *et al.*, 2006; Hogan, 1997; Hogan & Higgins, 2001a; Howe, 2005; Kandal, 1990; Kettinger *et al.*, 2000; Nair *et al.*, 2003; Sheridan, 1995; Smarsh Hogan *et al.*, 2006; Suchman & Luthar, 2000; Woods, 2000a). Nowhere was this more evident than in their own and their mothers' experiences of managing finances and households as self reports and professional worker accounts attest, all of which pointed to the issue of poverty. Although the terms *'marginalisation'*, *'exclusion'*, *'disadvantage'* and *'deprivation'* were used occasionally, the majority of professionals used the term *'poverty'* as descriptive of the social context in which the women lived. Several women mentioned poverty also, while others did not name it explicitly in discussion of their harsh living conditions.

The women's experiences unfolded against a backdrop of poverty in the midst of a booming 'Celtic tiger' economy in late 20th and early 21st century Dublin, referred to by many workers.

Understandably then the women expended much energy in managing poverty and limited finances, organising their households, *'keeping the fridge stocked'* and ensuring basic survival. As several respondents suggested, they were *'making a home in the hovel'* [Community Worker, W 06] or *'making silk purses out of sows' ears'* [Community Worker, W 04], as their mothers had done before them.

Consensus prevailed among professional workers that the women generally hailed from communities impacted upon across generations by long-term unemployment and educational disadvantage and that this poverty predated drug use.

> *The women drug users had the lowest self esteem that I'd ever come across in women and women in general, if you're working in this work, do have a low self esteem. But I found that the drug-using women were even, they didn't see theirselves as human beings...We're looking at three generations of poverty and ... then to get rid of the stereotypical of being a drug user, to move on from that.* [Community Drug Worker, W 38]

Within the communities where most of the women lived, drug availability and opportunities for exposure and access to illicit drugs were high and transgenerational problems with alcohol and psychoactive substances, licit and illicit, were common. An addiction counsellor [W 02] couched this issue in terms of gender roles.

> *I think that the way women are responded to in those areas is predominantly as child carers, is predominantly as secondary to the men and that the responsibility of men in the home is all but nil ...But the men are, will always be the ones who are served and I think that's handed down from the working mothers with the drinking husbands who are in general the parents of the client group that we work with.*

The professional workers espoused a definition of *'relative poverty'*, that is the experience of poverty is relative to the society and the wealth of the society in which it occurs. One worker [W 06] however compared the women's living conditions to those she had witnessed in Central America ten years before.

> *I'm amazed because the last time I would have experienced poverty like this would have been in Guatemala and you think that's Central America, sure we know about that. But it's here in the city, it's here in Dublin City . . . extremes . .*

Poverty was regarded as a female experience generally, one that women managed and was reportedly more pronounced for the woman drug user. Poverty was also linked with powerlessness, accounting for lengthy discussions about citizenship issues, democratic rights, access to services and to respectful treatment and dignity. Many also stressed the visibility and resulting vulnerability of the working class drug user in receipt of methadone maintenance treatment. Respondents repeatedly commented on the oppressive style of local anti-drugs activism, emphasising the exacerbated risks of poverty and homelessness for women and their children. Throughout, a plethora of issues, such as poor housing, lack of nutrition, lack of access to care for their physical, emotional and reproductive health, marginalisation, lack of education and literacy and general lack of supports, was mentioned.

This issue of poverty, relative and consistent, described qualitatively throughout although not quantitatively measured, cannot be ignored, figuring as it does in the accounts of many of 205 women and 100 professional workers encountered. The experience of poverty and unsupported motherhood, described in the women's and workers' accounts of women drug users as mothers, resonates with the experiences of Irish women generally (Kennedy, 2004), as discussed at the outset of this thesis. The women bear remarkable similarities to other women and mothers in the Republic of Ireland. One study of lone parents highlighted the poverty experienced by many participants, which is further accentuated by the lack of childcare and other resources (McCashin, 1996) as have a number of others have focused on Irish women's experiences of poverty and the gendered nature of the social security system (Cantillon, 1997; Cook & McCashin, 1997; Daly, 1989; European Commission, 2005; *The Irish Times*, February 15th, 2005: 10). The women had impressive repertoires, in the formal and informal economies, with regard to raising funds for both drug use and basic survival, 'taking care of the business'. Paradoxically, in fact while using drugs it was often reported that the women had more rather than less material and financial resources, also witnessed in other studies of women drug users or the children of drug-using parents (Bates *et al.*, 1999; Friedman & Alicea, 2001; Hogan & Higgins, 2001a; Taylor, 1993). Many identified coping with increased financial hardship as a result of ceasing criminal or informal fundraising activities when they stabilised or became drug free as a major challenge.

Like Taylor's participants (1993) they also rejected confinement to the domestic sphere, and wished to combine these traditional caring roles with education, work and community participation. This study offers much evidence of their dual career status. All five women who were drug free and parenting remained 'dual career' women, many involved in full-time education and work as did many women in receipt of methadone. Despite the best efforts of many around them, it appears, to restore them to the full-time socially approved and desirable role of attentive, care-giving mother, the women did not aspire to move from their *'fallen angel'* role of drug-using mother to that of the 'angel in the house',[99] exclusively concerned with housekeeping and childcare. It appears that while mothering was a constant in their lives, they swapped a career in drug use for one in education, drugs work and/or work in the social economy. All placed importance on the value of work and education. Significantly, many aspired to become involved in drugs work, counselling and social work world,[100] confirming Rosenbaum's claims that the world of drug treatment is often 'a bridge between addict and non-addict lifestyles' (1981:106).

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[99] In her review of women and crime, Heidensohn (1996) examined the notion of women and social control. Identifying areas of society where women's roles in the control of others are crucial, she drew on Victorian poet Coventry Patmore's image of 'The angel in the house' to discuss the traditional domestic sphere of the home, the 'private sphere' in which women have been both in control of others and are simultaneously controlled. Oakley (2002) too has used this idea of Angels in the House to discuss gender issues with regard to the division of labour in the home and the world.

[100] In this study three of the five drug free women were involved in service delivery to other users. Three women on methadone maintenance were also involved in the care of others, one woman running a peer programme for women affected by HIV, another working in a users' self organised group and yet another as a volunteer in a low threshold drug agency.

Performance and Survival

In this chapter, the women's lives as mothers are described as busy and challenging and sound remarkably similar to the experiences of their mothers, as recounted in the early section of the last chapter. These accounts challenge many other studies' findings about the exciting life pursued by women using drugs. The mundane existence of the women and the ordinariness of the women's lives described throughout cannot be ignored.

Not surprisingly perhaps, the women's central concerns are claimed to be related to their children's welfare. They also expressed concern about the emphasis on their mothering performance because of their drug use. Fears were constantly expressed about being viewed as an unfit parent, a concern identified by many studies about or among drug-using women (Boyd, 1999; Butler & Woods, 1992; Ettorre, 1992; Goode, 1999; Inciardi, 1993; Maher, 1990, 1992; Pearson *et al.,* 1987; Perry, 1979, 1987; Rosenbaum, 1979, 1981a, 1981b; Taylor, 1993; Woods, 2000a). While the women in discussion often defended their performance, they also expressed fears and feelings of inadequacy about being parents and about the tasks and processes involved. Also evident among workers was both the knowledge about the women's concerns in this regard and their own concerns and dilemmas about the fitness to parent issue. This 'unfit mother' notion and its impact on assessment and its outcome is one that is alluded to in a vast range of other studies, as noted earlier.

Despite many women's involvement in heroin use over lengthy periods, some managed to maintain the role and carry out the tasks central to parenting. Often normal parenting and household duties were regarded as more important than the drug use. Like women drug users elsewhere, the women engaged in a range of daytime activities. Whether using drugs, methadone maintained or drug free, according to the accounts of workers and the women's descriptions of their days, the women lived humdrum, repetitive, busy and mundane lives, caring for their partners, children, family members and *'cleaning, cleaning, cleaning'*. While using they had to combine these activities with earning the additional money necessary for the purchase of drugs, often at the same time supplying their partners' drug needs. While on methadone maintenance programmes they combined parenting with attendance at the clinic. Above all, struggles to be a *'good mother'* or at least a *'good enough'* mother and to succeed in caring for their children dominated their accounts. The majority aimed to *'do what any mother would do'*, look after their children, clean their houses, and *'keep it all together'.*

Normal everyday contact and interaction with children, family members, neighbours and community reportedly had little to do with drug use, as witnessed in another study of women's experiences of drug use (Taylor, 1993). While managing poverty, many also worked hard satisfying their partners' needs, while they co-parented with them. Their interactions with their families were also a part of their daily life, particularly the task of pleasing their mothers. Their drug-using activities, such as raising funds, scoring and using, rather than viewed as exciting activities (Rosenbaum, 1981a),

were often simply 'a taken-for-granted aspect of their lives ...not always at the forefront of their minds' (Taylor, 1993: 59). Like their mothers before them they engaged in several careers of parenting and work. Their involvement in drug use however brought further challenges.

Involvement in treatment services was also central for many and they made many compromises in order to stay in favour with the system. Most women feared losing partner or family support and drug treatment and the threat of eviction or homelessness, an issue that will be discussed in Chapter Seven, believing that if they lost their supports and homes they would in time inevitably lose their children to the care of others.

Women's everyday work in parenting while on heroin, on methadone or drug free offered a wealth of information about the intersection of the various careers. Regardless of the women's drug status at the time of interviews, many have parented while using drugs, while methadone maintained and while drug free. Their accounts demonstrated how they managed or failed to combine a career in drug use or drug treatment with that of motherhood and presented an overview of the impact of their drug use on their parenting and its impact on their drug use. While some described parenting as a motivating factor in their lives and their decisions about drug use, others described it as stressful, experiencing it as significantly less motivating as demonstrated in earlier studies (Hollis, 1998; Taylor, 1993).

Some were stressed by the motherhood experience and found that drug use commenced or was exacerbated after the birth of a first child or after subsequent births, as observed elsewhere (Goode, 1994). Several commenced drug use after a mothering career was well underway. Some believed that drug use enabled them to cope with the stresses thereby making them better mothers, as noted elsewhere (Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993) while others believed that they should stop taking drugs completely in order to attain a less stressful existence. The women expressed concerns about the impact of their children's exposure to drug use and the drug treatment system, believing that if they could *'keep things together'*, prevent them from seeing their parents use drugs and give them a good education, they could perhaps minimise the impacts. This concern about the impacts will be further explored in the next three chapters. However they also worried about the marginalisation of their children at school and in the community in which they live as identified in another Irish study (Hogan & Higgins, 2001a). Mothering was often a motivating factor for attempts to change their drug-using behaviour, to seek treatment or become drug free.

Conclusion

This chapter illustrated the centrality of doing motherhood on a daily basis in tandem with a drug career, a drug treatment career or with a prior history of drug use. However by virtue of their involvement in drug use and the resulting labelling and stigma, it appears that women drug users have to perform at a high standard and manage the two careers.

Many women participants experienced parenting at different stages of their drug-using careers. The majority experienced mothering at all three stages - as drug users, as methadone maintained users and as drug free or *'in recovery'*. Some also experienced motherhood before they ever used drugs. There were those who were content on methadone and felt that they had achieved stability in their lives and their children's lives. While the women described varying levels of immersion in a drug career while parenting and while a diverse range of experiences and outcomes emerged at different stages, many managed to control their involvement with the life, particularly where they became pregnant and made the transition to motherhood. The women combined their use with other, often more important, aspects of their lives.

In summary it is important to note that the accounts of women and professional workers suggest that the women did the bulk of the physical and emotional work of parenting. In some cases, partners provided company and emotional, moral and financial support. Sometimes mothers or other family members assisted. However, in the main, it was the women's role and responsibility to manage the finances, the poverty. All participants described how drug-using women worked hard trying to balance drug use and motherhood, drug treatment and parenting or the stigma arising from a past career in drug use and parenting. Sometimes this work was done while using, other times while involved in treatment and again other times while drug free. Almost all the women have had periods drug free. Triangulated accounts permit a range of experiences, pictures and views to come to the fore about the collision between drug use and motherhood and make explicit the tensions and dilemmas that exist.

The emphasis they placed on efforts to survive, to provide for children, to organise households and manage poverty was notable in that it reflected their mothers' experiences as women a generation earlier. Like their mothers, they engaged in several careers of parenting and work. Their involvement in drug use however brought additional challenges. The next chapter will look at the monitoring of motherhood by social workers and drug treatment providers.

CHAPTER SIX

MOTHERHOOD WATCHED: *'UNDER THE SPOTLIGHT'*

INTERACTIONS WITH THE AUDIENCE

> Why does the combination of drugs and children raise such enormous anxiety in us? ... The image of the bad mother is a terrible unspeakable notion, a mother using drugs is a clash of values affecting society's sense of emotional and moral security. (Kearney, 1994: 6)

Chapter Five explored the women's mothering experiences and performance at different stages of their drug-using careers. The women's concerns with and the workers' acknowledgement of the stigma associated with being both a drug user and a mother and the theme of performance recurred in the accounts throughout. This chapter will now explore how women drug users' motherhood performance and parenting capacity is responded to, watched and assessed by professional workers.

Throughout the literature about women's drug use, parental drug use and the children of drug-using parents, one of the strongest and most damaging images of women drug users emerging is that of unfit, uncaring mothers who choose drugs before their children. Many studies of drug-using women have explicitly identified such a phenomenon (Baker & Carson, 1999; Boyd, 1999; Colten, 1982; Ettorre, 1992; Friedman & Alicea, 2001; Goode, 1999; Klee, 1998; Neale, 2002; Perry, 1979, 1987; Smarsh Hogan *et al.,* 2006; Taylor, 1993). In addition, these and other authors in the social work field, while acknowledging the sometimes harmful effects of parental drug use on children, have problematised and questioned these images and assumptions and explored their impact on practice and interventions with this group (Adams, 1999; Billingham, 1999; Buchanan & Corby, 2005; Buchanan & Young, 2002; Butler, 1996, 2002e; Campion, 1995; Kearney, 1994; Klee, 1998; Norman-Bruce & Kearney, 1990).

This chapter firstly explores the women's interactions with professional workers. It then focuses on their interactions as mothers with the drug treatment system, overviews their involvement with statutory child protection social work services and revisits gendered expectations and practice. It then presents a typology of workers based on their reported approach to and optimism with regard to outcomes for women drug users as mothers. Throughout, it discusses the workers' views and perceptions of the women's performance as mothers, the women's views of service delivery and the dilemmas experienced by both groups.

Performance monitored

As discussed earlier, pregnancy and motherhood were powerful motivators for intervention. Subsequently, the women's parenting often came *'under the microscope'*, the *'very heavy wattage'* or *'spotlight'* and was watched closely by family members or partners. The women described how

they were watched and challenged informally by partners, parents and other family members or monitored officially by maternity, public health nurse or child protection services.

Many, mostly female, relatives offered support while simultaneously monitoring their parenting. Some women viewed this involvement alternately as helpful and as undermining their motherhood role, as described in Chapters Four and Seven. Alongside this family supervision, services sometimes intervened and assessed the situation. The 'three D's – doctors dealers and darlings' have been described as those who purportedly introduce women to drug use (Ettorre, 1992: 21; Johnson & Auerbach, 1984). Here the 'three P's' were partners, parents and professional workers, those who introduced women to service use or uptake and often mounted challenges to their mothering involvement. Relationships invariably involved both elements of caring and control, simultaneously 'empowering' or 'enabling' and 'coercive' or 'draconian' (Buchanan & Young, 2002; Campbell, 2000; Goode, 1999).

Throughout the literature terms such as 'scrutiny', 'monitoring', 'surveillance', and 'coercion' are used to describe professional interventions with such parents (Buchanan & Young, 2002; Campbell, 2000; Klee, 2002c; Kroll & Taylor, 2003). Surveillance and monitoring often reportedly impacted considerably on women's ability to parent effectively and meet their children's needs. Professional workers clearly suggested that women were often more anxious as parents and had to perform and prove themselves fit to parent as noted in the last chapter. They were also aware of the anxiety that their interventions provoked in the women.

> *They have no chance once they're expected to parent in public. They're parenting under a very, very heavy wattage in terms of surveillance. The spotlights are all over the place on them.* [Community Worker, W 34]

It was also suggested that there were often no clear expectations and guidelines offered to the women and that the *'goal posts'* with regard to professional expectations of parenting capacity and performance were inconsistent. The women also reported that they often received mixed messages about a range of issues and experiences. Many women reportedly resisted involvement with child protection social work services and were sometimes described as resistant, uncooperative and non-compliant, traits commonly attributed to mothers within statutory child protection systems (Scourfield, 2001, 2003).

All professional workers consulted were concerned about the issue of parenting and drug use and regarded working with these issues as challenging. Some described the work, the systems that had to be dealt with, the poverty, homelessness and deprivation, the lack or inadequacy of interagency cooperation and the uncertainty variously as *'complicated'*, *'a big haze'*, *'very difficult'*, *'frustrating'*, *'frightening'*, *'demoralising'* and *'unending'*. The workers outlined their child protection concerns, identifying incidents that created dilemmas and caused concern, as seen in the literature. Concerns with the nature, pattern, frequency and the lifestyle associated with the use were often central. Issues such as children's safety, children being left alone while parents went to

score drugs or raise funds, and children left unsupervised when their parents were stoned were raised. Inappropriate behaviours such as criminal activity, sexual activity or drug use in front of children were at points also raised. Simultaneously they were also aware of the importance of the children in their parents' lives and of the parents in the children's lives.

Many issues, other than safety concerns, emerged. Outward appearances and the conflicting values associated with parenting were often raised. Dressing a child perfectly was crucial in certain communities.

> *Most of them are parenting alone, love their kids absolutely, completely and utterly...Their experience is - you have to provide the best for the kids, that usually what's on display is clothes and stuff like that . . . There's a huge element of keeping up with the Jones' in this area . . . That's what happens in this community.* [Community Worker, W 04]

Conversely several workers challenged this notion, arguing that certain *'classist'* attitudes and practices reigned supreme in the views of professional workers towards issues of this nature.

> *I think, across the board, not just for drug-using parents but in most of our services, we are all very middle-class and uptight.* [Social Worker, W 23]

> *And it's the training and the judgements and the social class. You see for me it's definitely a social class perspective of understanding where those people are at, knowing how they got into that position and knowing that there are routes out of it. But they're not middle class routes out of it.* [Community Worker, W 34]

The women and others described their experiences of monitoring, control and supervision. Professional workers also argued that drug-using women, predominantly working-class, were subject to more vigilance and monitoring generally. As young working-class mothers, they may have been more vulnerable to monitoring, confirming the findings of several studies (Enos, 2001; Gillies, 2006; McMahon, 1995; Scourfield, 2003). Several workers also highlighted that women had to contend with the workers' often harsh and *'middle-class attitudes'*. Notably the women seldom made claims about differences in approaches pertaining to socio-economic, educational or class differences. When they were made, it was in fact middle-class women drug users who raised them. A majority referred to how women were expected to *'play a whole different ballgame'* with regard to drug use and with regard to parenting and drug use specifically.

Two main concerns were identified by workers. One was that inappropriate discussions between adults, sometimes professional workers, often took place in front of or inappropriate comments were made by parents and others directly to children. Children's awareness of their parents' drug use, their difficulties and depressions was heightened by the fact that they attended clinics and centres and witnessed their parents' interactions with medical, counselling and social work staff. Children then were often reportedly concerned about their parents' health and well-being. The workers focused on the children's experience, the love the women have for the children while raising issues about sometimes inappropriate parenting practices whereby children were treated as adults and friends with no clear boundaries or limits. The other concerned the number of alternative

carers involved in caring for children as a result of hospitalisation, imprisonment, movements, different placements, inconsistency or separation and loss, replicating other findings about separations and disruptions to care among children of drug-using parents (Akin & Gregoire, 1997; Carten, 1996; Enos, 2001; Fanshel, 1975; Hogan & Higgins, 2001a; Kovalesky, 1997, 2001; Kovalesky & Flagler, 1997; Regan *et al.,* 1987; Wellisch *et al.*, 1993)

Drug services were those most frequently attended, often on a daily basis, while contacts with child protection social workers occurred occasionally if there were concerns throughout the parenting career. While professional workers often have broader roles of care, treatment and duty of care to drug-using women in general, in this context their interactions with the women in terms of their mothering role as drug-involved mothers and their associated child protection concerns are the focus of the following sections.

Drug Treatment and Motherhood

As mentioned in Chapter One, when women's illicit drug use is discussed there is always a concern expressed for the foetuses, infants and children of those involved. While the centrality of the motherhood role in the lives of women drug users has been widely acknowledged in the literature, treatment services in Dublin and elsewhere often disregard women's issues generally and their concerns as mothers particularly (Butler & Woods, 1992; Dunne, 1995; Farrell, 2001; Nangle Connor, 2000; Reed, 1985; Rosenbaum, 1981a; Sargent, 1992; Woods, 1992, 2000a; Vogt, 1998). The paucity of childcare services and facilities for women and children in drug treatment services in the UK and Ireland has been highlighted despite focus on this issue since the late 1980s (DAWN, 1994; Moran, 1999) a situation that persists today (UISCE, 2006). However, children's issues have captured some attention of researchers and drug treatment providers in Dublin (Bowden, 1997; Hogan, 1997; Hogan & Higgins, 2001; McKeown *et al.*, 1993; McKeown & Fitzgerald, 2006; Shanks, 2000; Woods, 1994; Woods & Daly, 1995).

The drug treatment system featuring in this study consisted of an array of services, ranging from statutory medically focused clinics, including ancillary services such as counselling, community welfare and crèche facilities to community-based services such as needle exchange programmes, low threshold drop-in services, counselling services and educational and training programmes. Although the women reported involvement with a range of agencies throughout their drug careers, often simultaneously, many focused their discussion of treatment on *'the clinic'*, where they received methadone maintenance treatment.

Almost all the women participants had current or past contact with the treatment system, although several younger women with short histories of drug use had not yet been in contact with any agency. Most women not yet in contact with services anticipated future involvement, especially if their situations were becoming untenable. Of the 26 women interviewed, 25 (96.15%) had contact with services at some stages of their careers in drug use and a large number interviewed were in

current contact. In all, 22 women (84.61%) had been treated with methadone at some stage of their drug-using careers, of whom 16 were at that time on methadone programmes, three were drug free and three were using street drugs.

While 24 (60%) of the 40 professional workers interviewed worked in the drug treatment system itself, only six (15%) worked in the clinic context, four of them in medical or nursing roles. The other participants worked in a range of different services, often liaising with and working alongside those working in the clinics. The 100 worker participants, encountered in interview, focus group and during observation, had opinions and views about the drug treatment system and the women's interaction with the services.

Accessing treatment and losing control

As mentioned earlier, the women often asked for or were offered help as soon as their pregnancies became public knowledge or their parenting was compromised. Indeed, overwhelmingly in this study, one of the main forces identified as motivating women to look for or accept help for a drug problem was their children, the impact drug use was having on their mothering performance and their wish to be perceived as good mothers, as viewed elsewhere (Friedman & Alicea, 2001; Wilke, 1994; Wilke *et al.*, 2005). Women involved in motherhood were encouraged into treatment programmes earlier and once there, encouraged to stay and to comply with treatment regimes. In the women's accounts, seeking drug treatment or *'getting on the clinic'* was almost synonymous with seeking recognition as a *'good'* or *'fit'* mother, many women describing their first or later treatment contacts as influenced or motivated by pregnancy or motherhood. It has been suggested that disproportionate numbers of women over men on methadone treatment programmes in the US indicates women's readiness to ask for help (Rosenbaum, 1981b). Other studies also suggest that women come earlier for assistance (Anglin, Hser, & McGlothlin, 1987; Ettorre, 1992; Grella & Joshi, 1999; Hser, Anglin & Booth, 1987; Hser, Anglin, & McGlothlin, 1987; Hser *et al.*, 1997; Meier & Miller, 2000; Vogt, 1998).

Accessing treatment radically altered the life of the women in this situation as they were then exposed to a range of new experiences, including other sorts of vigilance and monitoring in the clinics. There was a consensus view among participants that women lost their independence and autonomy due to involvement with treatment services. The women all talked about power issues, expressing concerns that professional workers, particularly doctors, have *'a hold over you'* [Wendy]. The issues of power, control, punishment and rewards were central to the discussion.

> *That's like your life. You know that you're dependent on that methadone seven days a week. You need that, do you know what I mean, and it's like they're over you.* [Susie]

> *I just feel that so much power is taken away from you when you go into those clinics, particularly the women. Once you go into there they just seem to get a hold and they seem to have a very set, perceived way about how you should be and behave and what's OK and what's not. And it just seems to me that women*

have very little power once they go over that door. Then you're known to them as well. [Liz]

Many women and workers suggested that clinics were *'too free to give out the maintenances now'*, believing that it was a way of *'keeping tabs on you'*. Many women also talked of the doctors as male, using the term 'he' throughout and several workers also viewed the system, somewhat inaccurately, as one of men overseeing women.

> *I like to be in control, to make me own decisions rather than someone else making them for me, you know. ... At the end of the day I'm dependent on one man, that's that doctor, you know and he's controlling me life!* [Helen]

> *In the clinic you have a big a big daddy, a big brother or... I use the male image because it has that kind of control thing, that says "we're going to do it for you".* [Addiction Counsellor, W 02]

While most were relieved to be able to access treatment programmes, they described the distribution of methadone and urine testing as *'demeaning'*. Often the surveillance and difficulties experienced with interactions in the clinic created challenges for the women. Treatment compliance was perceived to be an important factor in determining, if challenged, whether their motherhood role was preserved. Also where children were in kinship or non-kinship care, they believed that compliance with treatment would enhance their chances of reunification. Most women believed that being in contact with the clinic and having their urines tested regularly meant that they could prove either to family or social workers that they were fit or good mothers because they were not using drugs. All the women mentioned feeling *'dirty'*, *'invaded'* and particularly disliked having to give urine samples while menstruating. They were also concerned about what their children might see or hear about urine testing.

Life 'on the clinic'

In discussion of drug treatment services, some women described good relationships with individual key workers, others perceived these in a less favourable light. However the women, while they had plenty to say about the services received, were not overly critical. Many believed that they *'can't complain'* and regarded themselves as *'lucky'* to have to accessed treatment and significant benefits, as witnessed in another study of women drug users (Dumas, 1992).

> *It's just that they have like priority over you....They just have power over you like. We depend on Phy and they know that. I find they have the power over you, the doctors, the nurses and everything. But I can't complain about the clinic because they have been very good to me.* [Marina]

When things worked for the women or were helpful, often it was the helpful attitude and demeanour of staff that were mentioned (Friedman & Alicea, 2001; Lilly *et al.*, 2000].

> *Their attitude! They didn't judge me. They wanted to help me to help meself, do you know what I mean. I didn't feel, they didn't treat me like a fuckin' victim or an imbecile or it serves you right or whatever. They'd compassion ...* [Katherine]

It seems for the women in this study that the social rather than medical issues and the social interactions predominated. While some studies have evaluated methadone maintenance treatment, focusing on outcomes, efficacy and treatment delivery (Ball & Ross, 1991; Ball *et al.*, 1988; Dole & Nyswander, 1965; Farrell *et al.*, 2000; Kreek, 1979, 1983; Ward *et al.,* 1998), others have studied drug users' experiences of exposure to such treatment (Montagne, 2002; Neale, 1998, 1999; UISCE, 2003). Few have focused on the interactions between the clinic staff and service users. Where they have (Friedman & Alicea, 2001; Hunt & Rosenbaum, 1998; Lilly *et al.,* 2000), the importance of examining the social processes rather than medical issues associated with the treatment experience has been stressed.

The women believed that treatment agencies and doctors undermined their decision-making powers with regard to a range of issues but particularly with regard to relationships, pregnancy and motherhood. While empowerment was mentioned by many professional workers in interview, some of the practices of the treatment system were described by others as controlling, one community worker [W 11] referring to the *'oppressive and repressive'* nature of drug treatment. Many women said that agencies exercised control over their relationships and strongly influenced and sometimes disapproved of their decisions or actions with regard to contraception and pregnancy, which has been documented previously in an Irish context (Butler & Woods, 1992; O'Neill, 1994; Shea, 1992; Woods, 1990). This was also mentioned in nine workers' accounts and several focus groups.

> *I think that even on reproductive issues for women drug users and there's a whole history of control - the use of depo provera and that's ongoing and it's not questioned.... The view is it's better if they don't have any more children...* [Social Worker, W 01]

As many women and workers stated throughout, they were obliged to perform and satisfy the expectations of many around them. A majority of women interviewed and focus group participants raised the issue of being mothers seeking, receiving or trying to leave treatment, focusing on the centrality of scrutiny.

> *I'd hate to be a mother going into a clinic now. I just would because you're really under scrutiny now.* [Laura]

> *They control how you are, how your parenting is going. They'd rather you, they'd rather see the kids coming with you. ... Your kids start to go into the whole way of being and that you know what was it?... Like my kids would say "the doctor is up there", "the crèche is down there", "you get your Phy there" and "you've to queue up there". They knew everything...and what does the clinic bring them?* [Andrea]

Bringing children to clinics troubled both the women and workers. Going to the clinic daily, seeing the same people often caused difficulties, an issue raised by several family members met during fieldwork and echoed by those interviewed in a recent study of family support in Dublin (Duggan, 2007).

> *And I think that is the difficulty now, that corralling people into specifically drug-using services that you create then a social network which is basically based on drug use and it's very hard then for people to have time to establish other kind*

of networks and other kinds of linkages with other groups and other people. [Social Worker, W 23]

The women expressed concern about their children witnessing their taking methadone in the same way as they had been concerned about their children witnessing their drug taking. Many were also conscious that their children did not like attending the clinic.

> *I keep them separate. .... I have to bring them with me sometimes. They know I get Phy. ... They know that's the medicine to make me get better. ... But I don't like bringin' the kids down the clinic. It's all drug talk and people stoned out of their head on something and someone is talkin' to me and they're stoned and my eldest young one is pullin' me away from them. She just doesn't like the atmosphere.* [Marina]

Indeed many women aspired to become drug free in order that their children not be exposed to the clinic and its routines.

Contradictory and uncertain views as well as dilemmas regarding this topic were expressed by workers. Some felt that children's attendance at clinics was reassuring and evidence that parents were not hiding from the authorities, while others felt concerned about the suitability and appropriateness of children accompanying their parents into such an environment. Attendance at methadone clinics with children was sometimes presented as evidence of poor or inadequate parenting.

> *Most of the women who were mothers and that was the vast, vast majority of them would bring the kids to the clinic with them. They would be very, they'd be showing off their child rather than hiding the child.* [Addiction Counsellor, W 02]

> *The difficulty of juggling, the children coming to clinics, where the children are being exposed to more than they needed to be exposed to you know, coming into the clinic and sort of listening to different conversations, knowing their mother's on medicine, the medication, knowing exactly what it is, all that sort of information or in maybe with the doctor even. Although it's good that they're there with the mother, they're not running amuck outside or going off. Their mother is caring for them. But there's something not quite right... there's a conflict I have there.* [Addiction Counsellor, W 36]

> *A mother bringing a child to a methadone clinic – now that would be seen as bad mothering.* [Social Worker, W 31]

Some, both women and workers, claimed that agencies were generally harsher on women drug users. However others asserted that traditionally drug agencies have treated women as victims, victims of their male partners particularly.

> *There's definitely a different reaction depending on who or what sort of woman they perceive you to be as to how they treat you and mostly I think they feel safer believing that men are the baddies leading us on ... Again maybe it ties back into that whole thing that women are holier than thou and that the mother, that this whole thing that a woman couldn't possibly want to do something like that, that there had to be a reason.* [Liz]

Many professional workers, despite evident discomfort discussing the issue of domestic violence, were negative about the women's partners. As a result of worker disapproval, the women viewed

workers as policing their relationships and often hid the existence or presence of partners in their lives from professional workers and from family members. Significantly several professional workers in drug treatment and social work services acknowledged their increased sense of security, safety and control where there was no male partner in the picture.

> *It's definitely easier and the women do better when the men have left for good or are locked up. But they want to be in relationships despite what we think, they want men in their lives and they want the status having a man brings.* [Community Worker, W 05]

> *The vast majority of people I work with are alone as parents and they are women, you know, and most of them have experienced abuse at the hands of men....It's better when they do disappear, it's better for the kids and the women and the women are able to move on a bit.* [Social Worker, W 31]

However, although the majority of the women in this study were lone parents, they were in fact often parenting in partnership with others. Women's involvement in relationships with partners was monitored, often discouraged and, according to many accounts, on occasion it was common for a woman to be treated by a clinic while her partner was not welcome or offered treatment. Several women described their current instability with regard to drug use because partners were not being treated, were excluded from or sanctioned by the clinic. One woman was asked by clinic-based dispensing staff to pass on medication to her sanctioned partner who was *'barred from the clinic'*.

Women were also reportedly expected to be obedient and compliant in their dealings with the treatment system. Adult women were often treated as children and regarded as helpless. Clinic personnel often told or threatened to tell women's mothers or partners about their drug use. One woman described how they told her they would tell her mother.

> *There I was a woman in my twenties with what, four children at that time and they said to me "we're going to inform your mother"...* [Fieldwork contact]

Other women told how their partners were informed and given information about their drug use, information that in some cases was used in custody disputes.

Throughout, it was reiterated that there are few treatment facilities particularly for women or mothers and even where there were now crèches in several agencies, they were often viewed with suspicion and distrust by the women, very few of whom were happy to leave their children with them. Some were concerned about surveillance while others were concerned about their children's exposure to other children of drug-using parents. Residential treatment was simply not an option for women who wanted to perform, defend and maintain their parenting role. Many women argued that they were treated differently to men and to non-drug-using women, but not necessarily in a sympathetic or supportive manner. Workers also expressed these views and concern about the lack of resources and imagination with regard to service delivery.

> *... a lot of mothers are reluctant if they want to go for treatment because their children are separated and there's a big fear around the children, even where the children are going to go. If they go into care, will they get them back? ...* [Social Worker, W 03]

> *I suppose, what it concerns me, as a clinician, is not to say that drug users are worse parents but to see the opportunities we are missing in our clinics, because I see some, a small proportion of drug users, and it is small, who are parents who are not coping well.... Lots of them are coping extremely well, and some of them are not coping well. But there's lots more who are coping well.* [Medical Practitioner, W 29]

Despite their relief that changes in the treatment system had occurred and that they could now access methadone maintenance, many women expressed concerns about methadone maintenance believing that methadone was more addictive than heroin in common with women studied elsewhere (Friedman & Alicea, 2001; Klee & Jackson, 1998; Rosenbaum, 1981a; Rosenbaum & Murphy, 1987). Similarly many professional workers perceived methadone as more addictive than heroin. This ambivalence towards methadone and their support for abstinence-oriented perspectives even where drug policy supports access to methadone and harm reduction has been documented among medical personnel (Caplehorn *et al.*, 1996), among social workers in the UK and US (Adams, 1999; Baldino, 2000), among Irish drug treatment providers (Butler, 1991, 2002a) and the public (Bryan *et al.*, 2000). Despite these concerns many professionals argued that the women had benefited from treatment with methadone, echoing the findings of other studies (Adams, 1999; Klee & Jackson, 1998; Rosenbaum & Murphy, 1987).

A considerable number of drugs workers, such as addiction counsellors, project workers, outreach workers, described their lack of confidence with regard to interacting with statutory child protection social workers, a group they described as often *'dismissive'* and *'not interested'* in their views. Eight social workers mentioned the bad reputation of the health board and that the arrogant and rude approach of some social workers does not help the situation greatly.

On the other hand, impromptu demands by social workers for information were reportedly made and the expectation was that, as one drug worker described it, *'we just hand it over like that'* with no consultation with supervisors. One woman [Liz] remarked that increasingly drug workers were *'uneasy talking about drug using and parenting in the same breath'* and were also fearful of dealing with and liaising with child protection social workers. This was echoed by some professional drug workers who described themselves variously as *'ignored'*, *'unsure'*, *'overwhelmed'* and *'under confident'* in their interactions with social workers. They believed that they lacked training in childcare issues but also pointed out that many social workers lacked knowledge and understanding of drugs issues (Buchanan & Corby, 2005; Mounteney & Shapiro, 1997; Woods, 1994). This reportedly rendered many agencies unconfident about advocating on behalf of drug-using mothers because the conventional wisdom seemed to be that drug use and mothering are incompatible. Medical professionals appeared to be more at ease interacting with social workers.

Disillusionment with treatment and 'wanting off'

Rosenbaum & Murphy (1987) suggested that women drug users' disillusionment with the methadone experience arose as a result of their perceptions of methadone or treatment related

health problems. However the experiences of the women in my study resembled those of the women participants in another US study focusing on survival within the clinic (Friedman & Alicea, 1995, 2001), which highlighted the issue of control and surveillance. Rarely mentioning methadone related health difficulties, the women were more focused in their concerns about the practices of the *'clinic'*, monitoring, the need for compliance, and the social fallout of their involvement with treatment, particularly their labelling as 'methadone mothers'.

The women described some workers' reluctance to see them detoxify and refusal to believe that people can succeed. Many were reluctant to take methadone and the majority did not wish to take it long-term, desiring to leave a life *'on methadone'* behind particularly as they did not want their children to witness their attendance at clinics, hospitals and drug treatment centres. The women's determination to *'come off'* both street drugs and substitution programmes has been observed in other studies (Friedman & Alicea, 2001; Sterk, 1999a).

> *I'm not planning to stay on me methadone forever, do you know what I mean? ... I love children. I'm going to have more children when I come off me methadone, you know.* [Susie]

> *I'll be off my Phy before she goes to school, please God.* [Wendy]

The women were somewhat perplexed as they discussed the professional workers', particularly doctors', reluctance to see them undergo detoxification and leave the *'clinic'*, its safety or surveillance. Nonetheless, workers constantly reiterated that they were *'not ready yet'*, or *'it's not the right time'*. Women's concerns about methadone were many, as they perceived others' perceptions of them as still dependent on a mood altering substance and as methadone mothers, discussed earlier. Indeed this feminisation or maternalisation of methadone was notable and witnessed at several clinics in Dublin, as noted elsewhere (Banwell, 2003; Friedman & Alicea, 2001; Hollis, 1998).[101] Consequently, some women reportedly left clinics without undergoing a medically supervised detoxification. Interestingly, they were the ones who often succeeded in remaining drug free in the long term.

The majority of the women participants currently in receipt of methadone anticipated detoxification, imagining a time in the future when they would be drug free. Almost all of the 16 women interviewed currently on methadone aspired to *'come off the Phy'*. Six women, all older women in their late thirties or early forties, felt they probably never would detoxify. The remainder, some younger, wanted to be off methadone for their children, in some cases so that they could retrieve them from care and in others not wanting their children to see them attending the clinic or to know about their drug histories. They felt that their authoritative stance with their children would be undermined. Many claimed that professional workers, especially doctors, were reluctant *'to let us go off the Phy'*. Five women talked at length about how they were discouraged from detoxifying, an issue which emerged regularly in focus groups and in professional worker interviews.

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[101] Significantly a study of treatment outcomes reported that a higher percentage of women than men (91% as opposed to 78%) were still in treatment after one year (Cox *et al.*, 2006: 11).

> *I was pushin' them everyday "Detox me, detox me. I don't want this baby born strung out". ..."You're giving me too much. I don't want it". ... That was me fear.* [Katherine]

> *Generally you're pregnant, you're maintained on methadone as soon as the services get their hands on you literally and even if you wanted to detox you're discouraged actively from doing it.* [Nurse, W 07]

The views and actions of medical practitioners also highlighted this reluctance.

> *It is so much easier to dole out the methadone and the social control... All of them want to detox! But again that has to be realistic because some of them can't be and I think you have to be realistic about it... But a lot of them think about it. ... Some of them will make it, some of them won't. But they have to be offered the choice.... The clients themselves are deciding themselves and not with a lot of help from ourselves.* [Medical Practitioner, W 30]

Still, several women optimistically planned future detoxification and aspired to a life beyond the control of drug treatment. While many women emphasised the controlling nature of the services, they recognised the difficulties inherent in the delivery of such services.

Alternately, most professional workers, including drug treatment professionals, expressed despondent views about the services (although not necessarily their own), some strongly claiming that services, statutory services particularly, have failed the women. Drug treatment providers for the most part, however, were optimistic and positive about the women, with whom they come in contact. They expressed considerable concerns about the structural issues affecting the women's lives, particularly poverty and homelessness. In summary, drug treatment offered services to the women that were often valued. However, many perceived the services as carrying out surveillance and monitoring, aiming to reform, encourage conformity and treatment compliance rather than transform, not just in terms of drug taking but also in terms of expectations with regard to motherhood.

Interactions with child protection social work services

> *There's the fear of "Oh Jesus if they think I'm not a fit mother, they'll take me kids. Even if I'm not on drugs". ... I don't like fuckin' social workers. ....* [Katherine]

In Taylor's ethnography, she observed that women drug users' role as mothers was that which brought most of them into contact with social workers, 'a relationship they would rather avoid' (1993: 116). While in this study too the women participants wished to avoid social workers, many *'escaped'* involvement or at least ongoing involvement. They *'kept social workers at bay'*. However, women had *'brushes'* or *'run ins'* with social workers, referrals to community care social workers from maternity hospital social workers, reports and investigations in the community and voluntary arrangements. Perhaps the view that social workers in Dublin do not generally hold negative or stereotypical views of women drug users (Butler, 1996; Clarke, 1994) arises from limited reported contact and the lack of studies to date with those on the receiving end of such services. Several small snapshot studies and commentaries (Daly, 1986; Woods, 1994; Woods & Daly, 1995) have

offered a picture with regard to the childcare issues and arrangements of families affected by drug use in the Irish context. However, while there has been some limited interest in the forms of commentaries and reviews of assessment or social workers' role generally with the addiction issue (Buckley *et al.,* 2006; Butler, 1996, 2002e; Cahillane, 2005; Clarke, 1994), there have been no in-depth studies focusing on the relationship between attitudes and practice or social work practice with drug-using mothers.

Twelve women interviewees (46.15%) had never been in contact with child protection social work services, as was the case for some focus groups and street contact participants, even in several cases where their children were in the care of others. Six (23.07%) had, sometimes extremely brief, past involvement, now terminated. Eight (30.76%) were currently in contact with the social work services. In total, 14 women (53.84%) had experienced contact with social workers. Estimates of the numbers of families and children affected by drug use in contact with community care social work teams are unavailable in Ireland (Ana Liffey Drug Project, 1998; Butler, 2002e; Woods, 1994; Woods & Daly, 1995). However, one small study recently reported that ten of 20 families in contact with child protection services were identified as affected by parental alcohol or drug use (Buckley *et al*, 2007). Involvement of drug users in child welfare services ranges from at least 40% to 80% in US studies (Grella *et al.*, 2006; Wilke *et al.*, 2005; Young *et al.*, 1998) and between 20% and 62% in the varying UK studies (Cleaver *et al.*, 1999; Kroll, 2004).

When social services intervened, they did so sometimes at the request of the woman herself. A minority initiated contact with HSE social workers themselves, while in most situations contact was involuntary. Frequently, women's mothers or other family members, the women's partners or ex-partners, the partners' family members or members of the community requested social work intervention.

Fourteen (35%) of the professional participants were qualified social workers,[102] working in a range of roles and agencies responding variously to drug users.[103] All but one had experience of child protection work. Six were currently based in HSE child protection teams. Hence, a range of experiences of drug-using women as mothers and the children of drug-using parents was discussed. These social workers' views and experiences appeared to depend less on their

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[102] The social workers had received a Certificate of Qualification in Social Work or a National Qualification in Social Work

[103] See Appendix V. Six were working in what could be called child welfare/ child protection settings, five in community care social work teams, in different roles but with child protection experience; the sixth social worker was heading up a children's project jointly managed by a community care agency and a voluntary agency. Two of these workers actually described themselves as *'child protection social workers'*, distinguishing themselves from other members of their profession working in different contexts and with different client groups. Two had experience as maternity hospital social workers, in two different maternity hospitals, one currently and one in the past. One was a probation and welfare officer, working within the prison system. Another was a social worker in a statutory drug treatment clinic. One was a drug worker in a non-statutory drug project, while another was a social worker working in a hospital-based HIV clinic. Two were no longer working in social work although they had had varying careers in child protection worker, drug treatment, and community work.

common professional background and training and more on the organisational and social context in which they worked and the extent of their knowledge about drugs and related issues.

A large number of impacts on children were revealed in interviews with professional workers, specifically child protection social workers. They identified many of these and described many issues that have been discussed in the literature review. Neglect was identified as a key problem, one that is often ignored. Children's safety, protection, emotional supports and education were also highlighted.

> *The consequences of drug use for children, it's so serious, you know. The damage drug use does in the long-term. It's so far-reaching and the levels of neglect that drug use causes, you know and the damage it does to kids. It's so abusive you know the neglect, the parents gone off shoplifting, the parents stoned, the children left alone, stuff like no food in the house, the flat being raided by the police, drugs being taken in the house, the terminology of drugs, the culture that become the norm of growing up as a child. The safety issues, the lack of supervision creates so much havoc for kids. There's emotional abuse at the very minimum....They're not able to prioritise their children.* [Social Worker, W 37]

> *It complicates in some cases the already difficult parent child relationship and I think it just puts it over the top ... Once they're on drugs, to my mind, it can put it right over .. The levels of neglect we would see with addiction would be something that would concern me and neglect is a really serious issue and I'm talking now about really active drug addicts now, not really those who dabble or on maintenance.* [Social Worker, W 32]

Several suggested that although there have always been some cases which are exceptionally negative, some of these cases have become more severe.

> *So you have really some rotten situations, you know, to be perfectly honest, of children being reared in really kind of completely and totally unsatisfactory situations, and where the system that surrounds and supports the parents who are rearing the children in those situations may indeed be quite powerful in opposing any intervention.* [Social Worker, W 15]

Some identified their own emotional responses about the experiences of the children.

> *I get very upset personally about the kids. A lot of the children I work with are very emotionally abused. A lot of the kids I work with have been sexually abused. The issue of children is huge.* [Social Worker, W 31].

However, although many identified these concerns and others mentioned earlier at the outset of this chapter about the impact of the parents' drug use or lifestyle on their children, it was notable that much of the discussion with workers who defined their target client group as the children centred on parenting practices, behaviours, attitudes, and the parents themselves. In fact, one child protection worker (W 37) suggested that one can be *'a bit blinded on occasion'* to the children's needs and concerns, her explanation suggesting that it was because the women themselves were so needy. However, the 'absent child' has been noted in another Irish study, specifically concerned with the decision-making processes in a child protection team (Buckley, 1998a, 2003).

Differing perspectives – integrated approaches or adversarial perspectives

All social worker participants, regardless of role or agency function, discussed the impact on parenting and family life of environmental factors, poverty and the multi-layered disadvantage experienced by the majority of their clientele. They were concerned about parenting and childcare issues and were conscious of the precariousness and challenging nature of this work. Differences emerged in the focus on the drugs issue.

As might be expected, social workers offered varying opinions about the parenting competency of drug-using mothers. Many had contact with a range of women, described as having a *'mixed bag'* experience of, involvement in and competency in parenting. For some women, their parenting involvement and competency appeared to be related to their involvement in current drug use, while for others crises such as relapse, illness, isolation, homelessness and other contingencies impacted upon their performance, as noted elsewhere (Campion, 1995).

Some workers, by virtue of their role in child protection, were in contact with those reported to them, those in crisis, those for whom the parenting role had created severe problems and whose children were at risk or those whose involvement in that role had been interrupted or terminated for a variety of reasons. These accounts on the whole described the most vulnerable women whose parenting comes under intense monitoring and assessment in order to maintain sufficient and adequate parenting.

On the basis of social workers' and other professionals' accounts, community care based social work services have moved from child and family welfare perspectives to almost exclusive concerns with protection, echoing other research findings (Buchanan & Young, 2002; Payne, 1997; Skehill, 1999; Walsh, 1999, 2000). For three child protection social workers, the needs of the child and parenting difficulties and deficits were the focus. While aware of the adversity facing drug-using mothers, two social workers appeared to express a view that drug use equates with poor parenting and that children experience difficulties directly related to their parents' use and resulting incapacity to parent. They particularly described themselves as *'child protection'* workers with *'statutory obligations'*, thereby distinguishing themselves from other social workers who were not HSE community care based personnel. The majority of people with whom they were in contact were people whose children were alleged to be *'at risk'* and in need of protection. Their perspectives seemed to support the views expressed by many that social workers espoused a belief that drug use *per se* impacts on parenting.

> *So we're meeting women and families where drugs is a serious issue and has really caused concern about the welfare of their children... My experience of some of the drug addicts that we've had, they haven't been successful parents. And really, I suppose this is a cliché, but drugs was their God and their priority!...I think that, I suppose, like I said, some of the mothers we get in here are at the end and I'm just not optimistic...* [Social Worker, W 32]

> *You have families and it's very chaotic and then they end up in a hostel...That's not the answer to throw them out of their home then as well...We get them*

when it's just a disaster really. There's so much than can be done before it gets that far... So I get it when it's broken down. [Social Worker, W 31]

While acknowledging that in social work departments they see women *'in very grave difficulties and at the end of their tether', these* workers emphasised women drug users' lack of insight into their children's needs as did a number of drugs workers.

> *They have very little awareness of their children's need a lot of the time. Just no insight! ...So I suppose I think that people can be supported to be adequate parents if they're on drugs. ... But if a referral comes in here and I see drugs is an issue my antenna go up, like with a range of things. So I would be looking more closely. And I do come with a bias or a prejudice thinking "Well if they're on drugs, what's happening when I'm not there?" and I have to work that out myself and look at that within myself. But I still do.* [Social Worker, W 32]

> *They don't see the impact their own behaviour has on their children. I think underneath it all they know, but it's too hard and painful to face it.* [Social Worker, W 37]

Expressing less optimism about women continuing as full-time parents, they believed that when cases have reached child protection services difficulties are already serious. One social worker (W 37) wondered aloud if women drug users could ever adequately care for and protect their children considering the damage undergone during their own childhood, especially as a result of sexual abuse. Another [W 32] expressed pessimism about the work.

> *Managing change with heavy users is very difficult.*

Another child protection worker found that the children of two thirds of her women clients had come into care, largely because of homelessness, problematic alcohol use and lack of support. While she too was despondent and critical of the resources and commitment pledged to this area, she expressed more concerns about poverty, structural issues and homelessness rather than about the women's parenting practices *per se*. Pessimistic views were evident among these three pressurised child protection workers.

> *But I look at them, their own experience of parenting and then their own trying to be parents and it's just I don't know where to go with it. I don't know where you start with Motivational Interviewing, solution focused therapy, with strengths perspective when things have gone so bad and broken down so much.* [Social Worker, W 31]

> *If you're working with parents and you're thinking of taking kids into care it can be very negative and you can't see some of the positive things because we do tend to focus on all the bad stuff. So there's probably good things that parents are doing with their kids that get missed... But there's so much negative that that becomes the focus.* [Social Worker, W 37]

Despite these views, they all described themselves as *'optimistic'*, believing *'in the possibility of change'* and expressing pleasure and *'amazement'* at some change and *'success stories'* observed.

Pessimistic views about the outcomes for women and family preservation, however, were not confined to community care based social workers. Several drug workers expressed similar views

at moments. In addition, one medical social worker in a general hospital also expressed some certainty that an expectant mother's drug use would impact negatively on her parenting.

> *We have one young one at the moment who's pregnant, and I mean, the child will have to be taken off her at birth because she is just so chaotic and lost to us.* [Social Worker, W 20]

Others, working in similar contexts in child protection teams, disagreed with this deterministic view of drug-using mothers. A further two social workers described their work as *'community work'* within community care teams and another managed a children's service in the context of a drug agency. However, they regularly had child protection briefs within the context of their work. They focused on the lack of resources, the poverty, the lack of accommodation and the family dynamics which affected the lives of women drug users involved in parenting and impacted on the welfare of their children.

> *I think that people can encounter difficulties in rearing their children. Sometimes that would be related to illicit drug use, but it can be related to lots of different things, so I suppose sometimes I have been happily surprised in dealing with families where I know there is regular drug use, and yet their children seem to be getting on quite well and things are kind of, certainly not falling within a serious-risk category. Usually they are families who have a good social network, they have the support network.* [Social Worker, W 23]

Despite the avowed importance of family support networks, support for families seemed to be lacking and to require the tariff of a 'risk' designation before they were allocated services.

> *Again I am thinking about a couple of particular families where there is a loving relationship between the mother and the children. But because of her drug use, because of her chaos, it's like, she doesn't need, the kids don't need to be taken into care. She doesn't want, she's not necessarily looking for social workers. She needs a family support worker. And in some areas, the only way to access family support workers is to get the case allocated to a social worker and they're only going to allocate a case to a social worker if the children are really physically at risk, you know what I mean, if there is a question of physical or sexual abuse.* [Social Worker, W 26]

In some cases, it appeared that unless the women were very seriously challenged or their children were at risk, there was little support forthcoming. Many workers pointed out that they tended to be less concerned if there was an extended family offering support to the women and caring for the children. However, there appeared to be few supports for the families in this position and few supports indeed for the women where conflicts arose.

> *... if there is an extended family there keeping an eye on the children, you are obviously less concerned. ... Because people do get upset if they see somebody who's goofing off, coming in pushing a pram, that always causes upset, doesn't it? But it doesn't happen that often. It really doesn't.* [Social Worker, W 20]

Those working in drug agencies, community work, prison and maternity hospitals highlighted the need to be well-informed and aware about structural and environmental issues. They also emphasised the importance of awareness and knowledge about drugs issues. Emphasising the importance of working with mothers (and sometimes fathers) and their children, they argued that family support and joint interventions, working in collaboration with clients were crucial. Those

working in community work particularly stressed the context and the importance of improving and increasing the resources in the environment in which people lived with their children. They argued cogently for the improvement of housing, the alleviation of homelessness, and development of childcare facilities, community after schools projects, family support services and children's projects. This group of workers identified strengths and competencies within their client groups and within the community.

The social workers, working in HSE drug treatment agencies and in non-statutory projects, believed that they should work to avoid creating an adversarial atmosphere. This was a key theme and differed significantly from several of those working in child protection services, who saw their role as ultimately adversarial as a result of their statutory obligations.

> *So it was a much more sort of preventative role that social workers would have had initially but they got swamped with protection. I think that the health board social workers are child centred and the drug services are often seen as adult centred and are then seen as poles apart.* [Medical Practitioner, W 28]

Clearly then, there was a lack of a consistent approach to drug-using parents and their children in this professional grouping. A difference in focus on children and adults emerged, as witnessed elsewhere (Mounteney & Shapiro, 1997; Murphy & Oulds, 2000). Of course, this was not peculiar to this grouping, particularly when looking at attitudes to drug users, treatment and child protection issues. Their views and opinions depended on the context in which they worked, the extent of their contact with drug users, their understanding of drug use, their view of structural issues, their acceptance or not of an adversarial perspective and their beliefs about the capacity of drug-using parents. While the risks of out-of-home care for children were always acknowledged, the difficulties with the lack of a coherent philosophy and a variety of understandings of drug use led to the varied experiences of social work interventions described by women drug users and workers alike. It appeared that a considerable number believed that the risks to children of remaining with the family in the kinship system or the mother were outweighed by those associated with separation from kin. There was agreement that the focus should be on keeping children and parents together.

> *...because really children should be at home. They shouldn't really be in care.* [Social Worker, W 26]

> *Taking children into care is the last resort. Care just doesn't work for children.* [Social Worker, W 37].

In the main, while often unsuccessful, family preservation was the stated objective of much of the work in which all social workers engaged.

Difficulties highlighted

A range of difficulties was highlighted including inappropriate referrals, inconsistency between community care areas and between workers' practice, the 'all down to drugs approach' (Hepburn, 1996; Rosenbaum & Irwin, 2000), generalisations, or the 'lottery' effect identified in the literature (Buchanan & Young, 2002). Concerns were also raised about the actual state of the child

protection system, its resources, poor management, lack of staff, staff turnover and enormous waiting lists.

Many professional workers raised the issue of inappropriate referrals and assessments of families where there appeared to be few difficulties. Both women and workers reported inconsistency between community care areas.[104] Some social workers were not overly concerned about a woman's drug use or treatment as long as the parenting was adequate. Others were concerned as soon as drug use was mentioned.

> *In terms of the kind of social work invariably that was brought to my attention through childcare issues and was very often other professionals responding to childcare issues in my understanding inappropriately to what was going on.* [Addiction Counsellor, W 02]

> *I'm telling you, if the issue of drugs comes up it's straight in and the kids are whipped out in some teams. In others they're working with too many drug cases and there'd be nowhere to put the kids if they acted that way. But it does depend on the area, the extent of poverty and drug use in the area and it depends on what the managers and the workers actually know about drugs.* [Social Worker, W 26]

Differences in standards were also observed between social workers.

> *Not at all consistent, not at all ... a lot of workers look for the easy way out which is often to convince the women to voluntarily place their children with their families. ... Again what do you judge proper parenting on? Is it your own values?* [Social Worker, W 31]

> *I think it's a really hard call to make, to draw the line what's good parenting and what has gone beyond what is acceptable, you know, and every social worker has a different measure of that. You're playing God all the time!* [Social Worker, W 37]

Some, with limited knowledge about drug use, were reported to act quickly whereas others more familiar with drug users were apparently measured in their responses. Some child protection workers appeared to be uninformed about harm reduction and indeed none used the term throughout interviews. They also talked about their clients' being *'in denial'* about their drug use, their children's needs, the impact of their drug use on their children and their parenting skills, again a trait often attributed to drug-using mothers (Taylor & Kroll, 2004).

Several social workers, like several of their drug treatment counterparts, also described methadone as more addictive than heroin and were generally uneasy, uninformed and ambivalent with regard to methadone and drugs issues generally.

> *It's difficult trying to get your head around the treatment services and trying to make sense of what methadone was and what Physeptone was, what different treatment methods involved. Even the whole area of methadone use, that's a*

[104] Some social workers and social work teams reportedly tolerate no illicit drug use whatsoever among clients, operating a zero tolerance policy with regard to illicit drugs and in some cases alcohol. One team reportedly expects methadone maintained or drug free clients/women to present clean, opiate-free urines for a three-month period before they may be considered as fit to parent or before the rest of the assessment may take place.

drug in itself. So in the end it becomes a big haze almost as a social worker almost to try and understand well if they're on methadone and they're still a bit stoned really are they still capable of looking after their kids. [Social Worker, W 37]

You see, I worry about methadone and this is talking about, I mean I would not see myself in any way an expert on drugs, let me say that very clearly...But I certainly think that some of the women that I've met through work here on methadone sometimes were more zonked, now this may be stupid, than even when they were using. [Social Worker, W 32]

The need for education with regard to drugs for social workers' formative and ongoing in-service training was also stressed.

I suppose the other thing, now to be very honest, I'd recommend, I would question how much education social workers have about drugs. I do question that and I do think it should be in their training. Certainly I have no expertise myself except what I've learned through working with other people and through the experience. But I think there should be a good education bit on it as well. [Social Worker, W 32]

One of the dangers is extreme positions and lack of knowledge because really we all have huge prejudices and assumptions and make assumptions about people. And social work is about trying to get rid of them but they're in us and the media feed us information and all that. So I think training is very important. [Social Worker, W 37]

Despite their preference that women be methadone maintained rather than using street drugs, they often stated that methadone itself was problematic and that the women were not *'addressing their addiction'* and *'not emotionally available to their kids'* [Social Worker, W 32]. This resonates with the women's earlier discussed concerns and fears about being perceived as still lacking something as *'methadone mothers'* despite their efforts to change. These findings about how professionals' knowledge, attitudes, understanding about and inconsistency towards drug use underlie many decisions made about parenting capacity have also been reported elsewhere (Adams, 1999; Bates *et al.*, 1999; Buchanan & Corby, 2005; Forrester & Harwin, 2004, 2006; Kearney, 1994).

Several workers referred to social work practice and interventions with drug-using parents in the early 1980s, some believing that there had been some changes while others questioned this.

In the past so it was believed generally that drug use constituted child neglect and children would be in care. ... Like what I was saying , I was right, they needed to look at childcare issues in relation to drug addiction ...They want the guidelines, they want to just go by the book ... You know, there's a knee jerk reaction with drug use – they're going all over the place! [Social Worker, W 13]

.... there is no doubt in my own mind that there were problems in relation to how the system was dealing with drug users, drug using parents at that particular time. I suppose what the institutions were trying to achieve, was to stop drug users from using drugs, and if that meant taking their children away from them, that became the norm. ... if a child of a drug user was not at risk, the issue was, well you had to monitor that to make sure ... you were kind of, I suppose, building up a case, basically, you know. But now I think there are less assumptions made about our inability to work with those parents ... it is less often that an assumption is made that because the child is in a family where

drugs are used that they need to be taken into care, for instance. [Social Worker, W 15]

Another concern expressed was that the interactions between the women and social work services actually gave rise to an anxious and defensive style of parenting, an issue which has been viewed elsewhere (Kearney *et al.,* 1994; Klee, 2002a; Murphy, 1992; Sargent, 1992) and is discussed in the context of this study in the next two chapters.

> *The fact that the spotlight is on their parenting, which promotes anxiety, but it promotes I suppose, an awareness of how important their children are to them. ...generally I would find that drug-using mothers are particularly involved with their children and care a lot about them. Unfortunately, they're trying to deal with their addiction that at times places them in dilemmas around what they expose the children to. And as I say, some will go to extreme lengths to protect their children from even knowing that they have a drug habit.* [Social Worker, W 23]

Defensive strategies and explanations were not peculiar to the women clients of drug or social work services. While the women described their mothering performance in defensive terms, it was noted that many social workers in interview presented their actions and work performance defensively. It is interesting too that other authors have mentioned how social workers too often behave and react defensively in the face of the hostility to them generally, resulting in negative outcomes for women (Bates *et al.,* 1999; Buchanan & Corby, 2005; Buchanan & Young, 2002). Speaking of the anxiety and uncertainty for drug-using parents, Klee (2002e: 263) has suggested that the 'failure of services to acknowledge this and neutralise those fears that originate in the services themselves perpetuates these responses'.

Several professional workers however stressed the difficult nature of the work.

> *I actually think social work in the Health Board is a much more difficult job than a drug worker. ... And it's much more hostile I have to say. ... They have a dreadfully difficult task to try and come in where things have broken down, or where often when things are breaking down, so it is much more difficult.* [Medical Practitioner, W 28]

As mentioned throughout, there are often serious concerns when parents use drugs. However many professional workers, including social workers, talked about *'the worst possible scenarios'* and the *'most memorable extreme cases'* at length. A concern emerged that these serious cases would be regarded as the norm for drug-using parents and was noted by several interviewees.

> *The risk always was that, you know, those fewer numbers* - (of drug-using parents in the 1980s) - *were being judged on the severity of one or two cases.* [Social Worker, W 15]

However, while the gravity of some of the situations experienced by children currently was acknowledged by workers, it was also observed that they tended to generalise the experiences of a few to the entire population of drug-using mothers and their families. When pressed to identify exactly how many cases demonstrated these difficulties, most of the workers, who were working in agencies with large numbers of drug users attending, offered responses such as *'a handful'*, *'three*

cases', 'two or three'.[105] Therefore, the vast majority of professional workers, including social workers, mentioned the infrequency with which they encountered such cases and situations.

> *Three, four or five. I suppose, again you are talking about small numbers.* [Social Worker, W 32]

> *I am thinking about a couple of situations where things are really out of hand.* [Social Worker, W 37]

> *In two or three families there are major issues.* [Addiction Counsellor, W 36]

Several workers expressed concern about the possibility of transgenerational reproduction of these patterns, an issue raised in the literature (Howe, 2005; Klee, 2002a). However, it appeared at moments as if many of these concerns were being applied to all families of drug users without discrimination or assessment.

Significantly, none of the social workers described the assessment process with drug-using parents or the children of drug-using parents. While they mentioned assessment, they did not describe how that assessment was carried out with such families. They talked about *'playing God'* and different decisions depending on different social workers. Many stated that drug use does not necessarily equate with poor parenting. They did not mention the use of any existing guidelines or assessment tools or frameworks (Billingham, 1999; Buckley *et al.*, 2006; Clarke, 1994; Cleaver *et al.*, 1999; Harbin & Murphy, 2000; LDTF, 1997; Mounteney & Shapiro, 1997; Murphy & Harbin, 2000). Several alluded to the need for *'guidelines', 'procedures', 'protocols', an 'instrument'.*

> *A lot of social workers have very strange views on domestic violence and on women using drugs and on women working on the streets as well, very, very strange views, very punitive....Protocols and guidelines are needed but you know you can't legislate for people's individual prejudices and everything else.* [Social Worker, W 31]

> *We have a huge statutory responsibility. We have to be very careful to protect children. We err on the side of caution because we don't have written policies and procedures that will inform our risk-taking...What is the policy about drug addiction? What are the standards? What is adequate parenting? And it ends up coming down to individuals making decisions ...and again I'm not trying to standardise everything 'cause you can't but there has to be some set of guidelines or set criteria or standards, an instrument. I mean I'm not saying tick the boxes but there should be some guidelines.* [Social Worker, W 32]

Overall, it appeared that practice experience, intuition, beliefs and assumptions held about drug users and the knowledge they possessed about drug use seemed to direct assessment as reported by the women and many workers.

It is difficult to discern unequivocally as to why drug-using parents were described as they were by child protection workers throughout. It appeared that social workers made certain assumptions about drug users, their fitness to parent and their parenting capacity and that these seemed to

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[105] What was also significant was that many respondents were talking about the same two or three cases, as there were often several agencies involved with a client and her family. This was information that could really only be accessed by a researcher with insider status.

impact on outcomes, as reported by the women and many workers. However, the child protection workers acknowledged that the serious cases they encountered were those that came to their attention when their drug use was chaotic and *'out of control'*. Their view of drug users, then, was to an extent informed by their practice experience, albeit an experience in the narrow context of statutory child protection. While one might speculate, one can only tentatively suggest that the 'master status' of drug user is applied from the outset of contact, as was suggested by several women and by workers. Therefore, at best limited practice experience and at worst stereotypical assumptions about drug users as parents impacted on social workers' views of all drug users, many of whom might be potential clients in the future as a result of encountering drug-related or non-drug related crises such as homelessness, domestic violence and children's welfare among others.

Several families came to the attention of child protection workers due to homelessness and illness, where temporary alternative care arrangements had to be considered for the children. However, in such situations the mothers' drug use or treatment status often became the focus of the intervention. In one case, a mother reported an assault on her child and asked for assistance and support. According to her own account and those of several workers involved with her, her status as a mother maintained on methadone attracted much attention and impacted on future outcomes.[106]

There was a consensus that social workers had enormous caseloads, social work teams in many areas were down to half their supposed size and that resources were not there for the allocating. Many participants expressed concerns about how low staffing levels impacted on the social workers' ability to respond and also acknowledged the overwork of these community care social work services. As mentioned earlier, some professional workers also highlighted the divisions between two different statutory services – HSE child protection services and the drug services. This was also reiterated by social workers interviewed.

Frequently, in the experience of the women and endorsed by many of the professionals workers' accounts, women drug users were regarded negatively by social workers. While the women in this study generally maintained that their *'children come first'*, several child protection social workers clearly viewed their drug-using women clients, and therefore all women drug users, as choosing not to put their children first. In discussion, they clearly adhered to similar views of drug-using women held by social workers in Scourfield's study (2003). While some drug-using women certainly were believed to prioritise their drug use rather than their children, a majority of workers highlighted that there are those who do prioritise their children, while there are also others who periodically oscillate between adequate and inadequate parenting as well as those who are those simply unable to provide for their children's needs in the midst of their drug use.

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[106] Her children are now in alternative care with two foster families, separated not just from their mother but also from each other. In addition, infrequent access has been facilitated and on all occasions has been supervised.

As women are ultimately responsible for the protection of children, they were regarded as being in a position where they must 'choose' between their partner or their children, their drug use or their children and between behaving badly or cooperating with social services (Scourfield, 2003). Significantly the absence of a partner in some cases in this study made it harder for the women to parent. Several women, who experienced domestic violence, did not leave partners because they did not want to take their children away from their fathers, as described in the last chapter. Sometimes it is reported that their drug use *'facilitated'* or reduced the stress associated with their parenting and indeed many felt that they were unable to offer their children the same resources and opportunities when their involvement in crime ceased.

> *Well now me ma gets paid for my kids, gets not adoption money, fostering money and only for that she wouldn't be able to give me kids what they're used to getting because you know I was a shoplifter.* [Rachel]

The women were reportedly regarded as not wanting their children if they did not fight for them or perceived as aggressive and non-compliant if they challenged social work interventions. Alternatively, challenging social workers was regarded as determination to preserve the motherhood role in certain cases. Significantly one social worker (W 37) stressed that drug-using families were easier to work with than families where alcohol was a concern, citing differences in hostility and aggression. She also emphasised the openness and cooperative nature of many drug users, with whom she has been in contact.

> *I'd find heroin users quite easy to deal with, quite likeable really because they're quite honest really, more honest because I think they're so overwhelmed by their problems and they're so out there. They don't bother hiding it it, that's what they are, that's what they're on, that's the situation...They are probably too open sometimes.*

Many interviewed believed that statutory child protection social workers betrayed the women and children in a range of ways. Perceptions of social workers were overwhelmingly negative. They themselves were aware of this.

> *The Health Board has such a bad name really. Some of the workers can be really rude and arrogant. ...There would be a very poor atmosphere in here, really bad actually and other agencies can see it, and a whole culture of people moving on, coming and going very quickly and you know 'this is a shit hole to work in' and all that kind of mentality. There's a lot of, a lack of energy around creating agency change or doing anything. I think good practice is all gone. It's become very much a fire service agency... People aren't working as hard to get relationships with parents so that maybe you don't have to go to court. There's a whole level of apathy really* [Social Worker, W 37]

> *I think people's perceptions of social work is true a lot of the time. And I think some social workers will remove children because it's easier, because it means that they don't have the confrontation and the challenge.* [Social Worker, W 31]

Many professional workers, particularly those in the drug treatment field, also questioned social workers' commitments to the women to assist them in their attempts to improve their parenting capacity and skills. They felt that they failed the women with regard to their children's future care arrangements and crucially with regard to access and regular contact with their children. Social

workers, they claimed, were never clear about exactly what was required from the women in terms of parenting capacity and performance.

An integrated response

While there were a number of social workers who saw their work as primarily child-centred and focused, the majority of professional workers, including social workers, argued for the need for an integrated approach to both mother and child. Concerns were expressed about the lack of family-friendly responses and family support, mentioned earlier.

> *There's nothing really happening for many of the mothers. It's really happening at the protection end of things or after the horse has already bolted.* [Social Worker, W 39]

Some expressed their beliefs that '*some of the women needed social workers themselves*' [Social Worker, W 37], that *'they need to be taken into care'* [Social Worker, 31] and to *'be minded, cared for'* [Social Worker, 26]. The women needed increased supports and advocacy, for example in terms of accommodation and housing and the coordination of their use of services. Where difficulties existed, often the response was reported to be swift and involved removing the child rapidly from the care of the mother rather than working with the family in question. Several argued compellingly that care plans were rarely developed and offered.

> *It's never about looking at a plan for keeping them together, providing systems of support, using the agency that is most likely to work with the woman and supporting that agency* [Community Worker, W 34].

The importance of working with both the mother and children was stressed throughout. The alternatives, such as mother-child separation, were regarded as too damaging in the long-term. A significant consensus existed among the workers and was also highlighted in focus groups that empowerment of parents and *'working with the women'* is essential.

> *It's not just working with the kids. It's to empower the parents that is so vitally important and teaching parents to understand because they weren't understood.* [Medical Practitioner, W 30]

These notions of working in partnership with women or collaboration arose regularly and echoed some of the language of social work and addiction focused therapeutic non-coercive perspectives such as the strengths perspective (Saleebey, 1997, 2002) and motivational interviewing (Miller & Rollnick, 2002). The question remains however whether the child protection services, drug services and women clients of these services can in fact be partners in the true sense of the word considering the power attributed to the services and the sometimes powerless, but often ambiguous status attributed to the women as gendered and classed subjects. These concerns have, as already mentioned, been explored in the recent social work and sociological literature (Enos, 2001; Gillies, 2006; McMahon, 1995; Scourfield, 2001, 2003).

The need for better interagency cooperation was also stressed, one social worker [W 37] describing it as *'crap, very poor'*. All the professional workers, including social workers, mentioned *'mistrust'* between a range of agencies, including between child protection and drug agencies. One

social worker [W 32] suggested that more openness, communication and working together might lead to a situation where

> *we might be able to maintain kids at home ...Oh definitely if there was more sharing the responsibility and the approach and valuing what each person has to bring.*

Social workers sometimes perceived some drug and alcohol agencies as *'punitive'*, not very *'user friendly'*, *'cooperative'* or *'helpful'* and only prepared to work with those already motivated, stable or drug free. Some voluntary drug agencies were regarded very highly but it was stressed that their focus was adult-centred and that while they are often very concerned about child protection *'they don't want to be in there saying it'* [W 31].

The women's views

The women had varying experiences to relate, both positive and negative. All without exception were fearful of social workers. Several women mentioned that their social workers were helpful to them even if they did not like the outcome or end result of their interactions, some describing how they were prodded into action by such contact.

> *It was the best thing to happen because it really opened my eyes. ... I knew I was going to lose my son and end up taking drugs for the rest of my life so I just snapped out of it.* [Emma]

> *Well, social workers over the years, at the beginning I used to "You're not getting in" growl, growl. "No. No, I want nothing to do with yous". But it took time to see what they were saying to me was right and when I copped on to that through help from our counselling services.* [Sharon]

Others were confused about the outcomes of their contact with social workers and expressed negative views.

> *My kids are all in care and it was just because of drugs. I had a good arrangement and lots of family support. .... I see women on the street pushing buggies from here to there and no one seems to be worried. I don't understand why some get attention and some don't. I had social workers when I had the babies and they were happy with how I was doing. Then this other one said "you stop taking drugs or else". I said "I'm on methadone" She said "that's not good enough, you should be drug free".* [Fieldwork contact]

> *I fuckin' hate my social worker. He thinks that drug users shouldn't have kids. He told me that... I wish I didn't have to see him but I want to see the kids for access and stuff like that..* [Focus Group participant]

Some women described some of the social workers they encountered as inexperienced, young recently graduated, having come recently to the area, not parents themselves. These social workers, almost always women, were seen as novices and regarded as *'cutting their teeth on us'* [Elaine]. This view was echoed by three community care social workers who were highly critical of their younger and newer colleagues' *'use of self'* in the context of the work, their *'bringing their own personal baggage and unresolved issues'*, *'prejudicial views and attitudes'* and their *'lack of respect'* in their interactions with clients.

Several women were aware of the stress levels experienced by the social workers and the gaps in understanding between services.

> *The woman doesn't even know what she's doing half the time. She has too many cases on her hands. She can't handle it.* [Ethna]

The assessment experience was one that was feared.

> *They wanted me to put them into care cause I was sick. I said "No". So rather than that they went to family and me Ma's their legal guardian. But then they said to me Ma that she had to put them in care to be checked out to get the money. We said "NO!" cause we were afraid it was a way of taking them. But then we did allow it.* [Rachel]

The lack of clarity about social workers' expectations of them were raised constantly by women. Many women believed that the inevitable outcome of interactions with social workers was the loss of the motherhood role, which was why they often determined to *'keep social workers at bay'*. Many women were relatively successful at keeping the social workers *'away from the door'* or *'off our backs'*.

> *I would have been constantly keeping them at bay and I would have had family support. I would have had me sisters and me Ma and me auntie. That was there constantly. Right? If things were bad in me life it was like "Get a grip, Andrea. We're taking the kids. They're not getting looked after". Like they would have been neglected at one point, you know. I wouldn't get up. I couldn't get up unless I 'd drugs ...So I think all the time my family pointed out stuff like that, you know.* [Andrea]

> *Well what I did... the social workers would knock. I wouldn't answer. I left it. For years I never answered the door. So that's how I got them off me back ... so I'd never let them in so they wouldn't know anything then, do you know that way. I didn't mind the baby nurse but I wasn't letting the social workers in.* [Laura]

Social work involvement also reportedly served to further perpetuate the process of infantilisation and dependency earlier initiated by families and drug treatment services. In addition social workers' current *'newfound interests in the category of drug-using parents and their children'*, as observed by a number of workers, raised some concerns. As mentioned earlier, communication between social workers and drug workers and treatment providers was occasionally viewed as problematic.

In summary, the preceding sections have presented findings about the women and workers' views of the interactions between drug-using mothers and the child protection system. While the conventional wisdom seemed to be that drug use and mothering are often incompatible, a range of views and experiences were discussed. In the main, however, the extreme difficulties often facing women in this situation both before and after such interventions were highlighted.

Gender Issues: From Fallen Angels to 'Angels in the House'

In earlier chapters, gendered expectations and experiences were discussed. In interaction with families, drug treatment and social work services, a series of processes commenced whereby women worked to please their assessors, prove their fitness to parent and perform for the services. They are often expected to meet the gendered, traditional and often conflicting expectations of their

families, partners, communities and the professional services. However whereas many have suggested that women drug users hold traditional and conservative views and opinions about womanhood and motherhood, Taylor's (1993) study showed that women sought more than to become housewives and mothers. This study's findings echo Taylor's in that the women aspire to a range of achievements and roles alongside their parenting and mothering role, as evidenced by their involvement in a range of educational and work activities. The importance of these roles and activities in replacing the daily activities associated with their drug use, also seen in other studies of drug users (Faupel, 1991; Mayock, 2003; Neale, 2002), was evident in Chapter Five, where many of those who were currently maintained on methadone and all of those who had become drug free reported their involvement in work and education.

It was evident that the women claimed an identity as mothers that differed greatly from that which they ascribed to fathers, in a similar manner to the non-drug-using women participants in studies of motherhood elsewhere (McMahon, 1995; Gillies, 2006). However looking at the practice and responses of services, it is interesting to note that drug treatment and social work practice too appeared to be quite gendered. Social workers and drug treatment providers reportedly ascribed a different role and status to women as parents/mothers than they did to men as parents/fathers. The women differentiated also between their experiences as mothers impacted upon by drug use and their male counterparts' experiences as fathers, as did the workers. According to several workers, the men's imbibing of alcohol or drugs did not lead to corresponding challenges to the fatherhood role.

Professional worker respondents also highlighted the gendered nature of the drug treatment and social work responses in identifying the notion of involving fathers, particularly drug-using fathers, in care plans as *'almost comical'*. In the event of alternative care arrangements or support for the woman drug user and her children, it was other women within the kinship system - aunts, sisters, mothers and even grandmothers - who were called upon by workers.

> *I think that social workers, all of us, don't see men because it's always the women that you're linking with.* [Social Worker, W 23]

> *Fathers, particularly drug-using fathers are left out of the equation. So the responsibility around the whole thing tends to fall with women.* [Social Worker, W 26]

> *In some cases I've seen drug-using men who have been great fathers but they have been viewed negatively and with suspicion. I'd love to see very specific attempts being made to involve men more in their families and children's lives.* [Social Worker, W 01]

Workers often mentioned how they attempted to intervene with partners but how generally childcare was gendered and the responsibility of women, as discussed earlier.

> *Well oftentimes I was like a Mammy giving out to partners. ... A lot of the girls, their partners were drug users as well which was something that was very, very difficult because they were the ones who had to do everything, everything in relation to their kids. And that's the way that the services are structured in*

community care as well. It's up to the women basically to look after the kids. .. it's up to (her) to protect her children all the time. [Social Worker, W 09]

We have no problem going in there expecting women who are having the shit kicked out of them to do this, expecting women who are strung out to meet our standards of parenting and everything and we just put the focus on women all the time. The focus will be on her and her being a bad mother. Not the partner who often says 'look at her - she's a useless mother!' [Social Worker, W 31]

However whereas there was often exclusion or 'filtering out' (Buckley, 1998b) of fathers, these were drug-using fathers. Occasionally it was reported that estranged non-drug-using fathers were regarded as more appropriate parents than their drug-using or methadone maintained mothers. Several workers described how non-drug-using partners or former users, some methadone maintained, may now be perceived as more 'fit' to parent than their drug-using or methadone maintained female partner. One social worker related the case of her now drug free client whose children were now being cared for by her methadone maintained partner.

Unfortunately the father of her children, who was an extremely violent man, he took the children on an access visit and he heard that she was in another relationship and he never returned the children. It's two years and he still has those children and he ended up getting custody in the courts. He even has another woman now looking after them. It was a real example of how women are treated so differently and how they are viewed so differently. You know she hasn't touched drugs in two year. But it hasn't benefited her as a mother 'cause she has lost her children. [Social Worker, W 31]

This social worker's account highlights an inconsistency in responses to men and women as parents that emerged as an issue occasionally in interviews. However the *'double standards'* experienced by the women drug users were reported throughout. The women and many workers agreed that women's, particularly mothers', drug use was perceived as worse than men's and challenges to the motherhood role were often illustrative of this attitude.

There are huge gendered expectations of the women as mothers, as primary caretakers. The women get the abuse from the system because "You're not minding your kids". But nobody goes to the fathers and says "Well you're not minding your kids"... you have that whole scenario where the man is saying "Well there's nothing wrong with me. It's her! She's their mother and she's on drugs". [Social Worker, W 37]

Like the men can go out use drugs for what, five ten years, come back in "I'm clean", give a few clean urines, take custody of some woman's kids who's after bearing them and rearing them, do you know. [Darina]

I put it this way. I said to her (the social worker) *"if it was a man that was the parent and he went on drugs what would happen?" "He'd have to prove he was a good father". "But you're after saying "A good mother doesn't take drugs or drink"". So I said the same thing should go...the same goes* for a man. *Well she says, "We all know men drink". So it's ok for a man to do what he wants but not a woman. She's just off her head.* [Ethna]

Treatment agencies' agendas, by all accounts included attempts to restore or return the women to appropriate womanly and motherly roles and behaviours, to the 'angel in the house' role. The women were aware, it seems, of workers' views that they should be keeping *'a good house'* and

that women drug users were generally regarded as unable to do this. Several women believed that this illustrated how they were regarded.

> *And they saw how like me house was clean an' how I was an' all. ... Me Probation Officer used to call around to me and she couldn't get over it like the way I had me house like.* [Wendy]

> *...Like people walk into my home and they look around and they say "Jesus you'd never think you were on drugs". What's your home got to do with it, you know what I mean?* [Darina]

Often agencies resorted to parenting programmes as the sole women centred response. Although some professional workers supported this approach, the majority was concerned that this alienated women considerably and further undermined them in their mothering roles.

> *Say a public health nurse said to you, I think there is a good parenting skills group that you could join, you'd die! The message is – you're not good enough.* [Social Worker, W 23]

> *No one ever suggests that the Das look after the children or need to do better. It's all left up to us women.* [Jenny]

Training programmes were reportedly gendered in expectations also and their curricula were often affected by the participants' gender, some promoting what were regarded as gender appropriate subjects and activities.

> *Now they were in a treatment programme, they were askin' for something to do. ... So they fell for all the general things like cookin' and sewin', the blah, blah, blah and I just couldn't do that ... I don't want to be goin' down the stereotypical road.* [Community Drug Worker, W 38]

> *There's a view that that's what you do with working class women, you provide knitting and sewing, parenting courses and the same shit is being trotted out now 20 years later.* [Community Worker, W 34]

The traditional, conservative and gendered perspectives of the drug treatment and social work field were noted by many. These findings of course mirror issues reviewed in the literature about the drug treatment system often claimed to be patriarchal, setting out to meet men's needs generally without acknowledgement of women's often qualitatively different needs. Additionally, it has also often been found that addiction treatment professionals approach women as already gendered subjects (Ettorre, 1992; Raine, 2001; Thom, 1994). In a similar vein, some of the social work literature has also problematised the gendered nature of social work practice and supports the view that when childcare, child welfare and child protection come into the picture women generally are treated differently to men (Ammerman *et al.*, 1999; Buckley, 1998b; 2000, 2003; Featherstone, 1998, 2004; Kroll & Taylor, 2003; O'Hagan, 1997; Scourfield, 2001, 2003).

Non-believers, Pessimists, Pragmatists and Resisters

With regard to the attitudes and actions of those who as professional workers monitor the women's parenting, on the basis of accounts it appears that a typology of workers emerges. Four groups of workers with specific views were described by those workers and women interviewed, who are named here as the non-believers, pessimists, pragmatists and resisters.

The non-believers are those described as committed to disbelief, pessimism and the application of the master status of drug user, described as those perhaps least likely to work well offering family support to drug users (Adams, 1999; Akin & Gregoire, 1997).

The pessimists are constantly worried that *'something might go wrong'* if drugs are being used and are often happier when children are placed in the care of someone other than their parents. They too tend to regard the women first as drug users and second as mothers. A large number of social workers particularly and some drugs workers were reported as belonging to this group, also described as displaying little optimism in terms of outcomes for drug-using mothers or families where drug use is an issue. Some of this group appeared to be unsure and underconfident about their role in responding to parents with drug problems, highlighting the impact of little role legitimacy, adequacy or support for proactive interventions and family support with such parents (Butler, 1996, 2002e; Cartwright, 1980; Shaw *et al.*, 1978)

The pragmatists are optimistic, while concerned and realistic, about the impact of drug use on parenting and on the women's children. They argue that a full appreciation and assessment of parenting skills rather than a focus on drug use *per se* in isolation is necessary. This perspective has appeared in the literature in recent times (Buchanan & Corby, 2005; Butler, 1996, 2002e; Clarke, 1994; Forrester, 2000; Forrester & Harwin, 2004, 2006; Harbin & Murphy, 2000; Murphy & Harbin, 2000; Woods, 1994, 2000a).

The resisters unrealistically reject the possible impact of drug use on mothering and refuse to accept any negative interpretation of these experiences at all. Among these, there is a reported observed tendency to simply ignore or neglect child protection issues and to regard the sole objective as keeping mothers and children together. Some social workers interviewed suggested that drug agencies were unconcerned about the issues and adult centred, an issue that arises in the literature at points (Barnard, 1999; McKeganey *et al.*, 2002; Mounteney & Shapiro, 1997; Murphy & Oulds, 2000; Powis *et al.*, 2000).

The majority of participants then appeared to fall into either the pessimists or pragmatists rather then the two extreme positions. As in Adams' study (1999), few were found to hold extreme views. However while several, generally social workers, described the actions and words of practitioners, usually those medical, nursing and counselling staff in statutory or non-statutory drug treatment agencies, as resisters, no participant interviewed appeared to fall into this grouping. In addition it is interesting to note that none of the women presented the argument that mothers and children should stay together regardless.

While the issue of parenting and childcare concerned all the workers, five of the 40 professional workers (12.5%) interviewed, and one of the 26 women (3.84%) interviewed, claimed that drug use itself was indicative of bad parenting and that drug users generally displayed poor parenting skills

and capacity, possibly drawing on the 'master status' notion. However in discussion they generally contradicted themselves and modified their views considerably, arguing that many of the concerns outlined throughout related to some or a few families rather than all the families with whom they were in contact. Others stressed that while drug-using mothers and their children were often at risk, they were rarely any more or less at risk than other women of the same age group, education and background. Few professional workers described women drug users as *'bad mothers'*. Some asserted that they consistently attempted to be professional in their judgements, to contextualise the experiences of the parents and children, to balance the needs and to evaluate in a relative manner the impact of the care and experiences of the children.

On the basis of much of the evidence, professional workers regardless of professional background or discipline appear to lack confidence and knowledge about working with drug users who are mothers. The 'all down to drugs' notion often dominated accounts. Many drugs workers and women highlighted social workers' lack of understanding and knowledge about drugs. However this ambivalence about methadone and harm reduction generally was also observed and reported among drug treatment professionals. This knowledge reportedly varied considerably depending on the experience, context and agency function of the social workers, as has been found here and in other locations (Adams, 1999; Akin & Gregoire, 1997; Bates *et al.*, 1999; Buchanan & Corby, 2005; Buchanan & Young, 2002; Butler, 1996, 2002e). The women also believed that social workers and drug treatment professionals understood little about methadone and viewed them as *'methadone mums'*, nearly as bad as *'junkie mothers'*. The tendency by treatment professionals and medical personnel to view women maintained on methadone in the same negative way as women currently using drugs has also been viewed elsewhere (Banwell, 2003; Friedman & Alicea, 2000; Raine, 2001, Rosenbaum, 1981)

Many social workers claimed to espouse views about women drug users, which reflected tolerance, sympathy and support. Some were less positive in the long-term about the prospects for women continuing as full-time parents. Other social workers were less diagnostic, adopting strengths-focused perspectives (Butler, 1996; Saleebey, 1997, 2000; Woods, 2000b) highlighting how people can indeed benefit from adversity (McMillan, 1999). One social worker talked about the need to reject a *'technical rationality perspective'* (Gowdy, 1994; Schon, 1983) which ignores strengths, social context, the importance of human interaction and sense of belonging.

The women described their treatment experiences, care plans, interventions, outcomes and their circumstances using a range of discourses and language, medical, psychotherapeutic, social work and legal terminologies, as witnessed elsewhere in studies of alcohol or drug users (Denzin, 1987; Etherington, 2006; Friedman & Alicea, 2001). These systems appeared to have introduced the women to a discourse which pathologised them, individualising responsibilitity while homogenising their experiences (Ettorre, 1992; Friedman & Alicea, 2001). They were view as *'damaged', 'broken', 'sad'* and *'victims'*. Victimised as children, it was suggested by a considerable number of

respondents that they are then regarded as *'irreparable'*, their identities fixed (Etherington, 2006). The women believed that they were viewed by many, but particularly social workers, as inevitable victimisers of their own children.

The views held by a minority of professional workers indicated a disbelief in or pessimism about women's ability to overcome childhood abuse and adversity and parent their children successfully, protecting them from harms from which they had not been protected as children. Such views uttered by professional workers almost precluded any social work, counselling, drug work or other interventions or responses, also observed in a study of a social work team in Dublin where workers appeared to 'filter out' and not engage with cases about which they believed nothing could be done (Buckley, 1998a). Several believed that women who had been sexually or physically abused as children or had experienced domestic violence as adults were likely to be less fit or unfit as parents and particularly unable to protect their children from harm. This belief that all was systemic, transgenerational, the cycle unbreakable was common and reflected many workers affiliation with systemic family therapy type models of analysis. Their pessimism, however, often suggested their lack of belief in the productive use of such models. The end result was often that workers asserted that women become parents too young and are bound to repeat the mistakes their elders made. A belief that *'the cycle will be repeated'* and that their children will be victimised seemed to prevail among many workers, while the women confidently asserted that much they have done in parenting differed from their parents' performance a generation earlier.

As opposed to the views of several social workers, the vast majority of professional worker respondents expressed the view that the women's parenting skills were affected less by drug use and by the drugs which they used and more by their experience of poverty and the circumstances in which they lived. In fact many respondents made it quite clear that it was their considered opinion that poverty rather than drug use was the major issue in the lives of the parents and children they encountered. In almost every interview they also argued that the women's apprenticeship in parenting, that is, their own experience of having been parented, had a considerable impact. Significantly despite these opinions, their ambivalence and discomfort with regard to the issue of drug use and parenting was evident throughout.

In recent studies of family support and the experiences of families of heroin users seeking services commissioned by NACD (Duggan, 2007; Watters & Byrne, 2004) issues about role legitimacy, adequacy and support have arisen and in the Watters & Byrne study were evident among a broad range of family support services with regard to responding to drug issues. It emerged that there was considerable insecurity experienced in dealing with families with drug problems.[107] This is mirrored in this study of service providers in the drug treatment sector and social work services and has been documented in other Irish and international literature (Adams, 1999; Billingham, 1999;

[107] While 65% of the services providers interviewed believed that they had a legitimate role in responding to drug-using clients, only 40% believed that they possessed the necessary skills and knowledge.

Butler, 1996, 2002e; Cartwright, 1980; Forrester & Harwin, 2006; Shaw et al, 1978; Taylor & Kroll 2006).

Some drug workers reported their lack of confidence about interacting with child protection social workers, identifying some as rude, arrogant and difficult to deal with, an issue that was also raised by several child protection social workers about some colleagues' behaviour. Several child protection social workers expressed negative views of and opinions about counsellors, drug workers and doctors and nursing personnel engaged in the drug treatment services. Others however spoke highly of several voluntary drug projects and their workers, and while acknowledging their adult-centredness, still argued that this cooperation and working together was essential. Several believed that these projects succeeded in *'maintaining'* families.

Several social workers, and those exclusively responding to children's needs, asserted that an adult-centred focus and a concern with the drug-using parents' needs was the *'comfort zone'* for drug agencies responding to individuals with drug problems. Conversely, drug treatment providers argued that a decontextualised child-focused perspective represented the *'blinkered stance'* of many social work practitioners and led to the exclusion of a focus on the needs of drug-using parents. This difference in perspective highlights the lack of interagency cooperation and communication so often alluded to in the literature (Barlow, 2004; Bates *et al.*, 1999; Buchanan & Corby, 2005; Clarke, 1994; Forrester & Harwin, 2006; Grella *et al.*, 2006; Harbin & Murphy, 2000; Kearney, 1994; Keen & Alison, 2001; Kroll & Taylor, 2003; Mounteney & Shapiro, 1997; Murphy & Oulds, 2000; Rickford, 1996; Taylor & Kroll, 2004; Woods, 1994).

Also suggested by many accounts from both groups was that intervention by service providers regularly impacted negatively on women and children and the outcomes in terms of continued parenting and custody. This finding echoes those of other studies suggesting that attitudes and actions of workers could enhance or damage their clients' progress (Adams, 1999; Akin & Gregoire, 1997). Indeed Adams' study found that negative attitudes could seriously impact on drug users and their families and were inconsistent with a family support perspective.

The women's relationship with services and professional workers was reported as frequently problematic. The relationships between social workers and the women were often strained, as were their relationships with others in the drug treatment and medical and nursing fields. It was often suggested by professional workers that while women's relationships with any powerful partner, parent or professional could be helpful and supportive it could also be counterproductive in that the expectation of a childlike compliance may lead to infantilisation, dependency and a loss of responsibility. This often led to further dependency of women on professional workers.

Despite the avowed importance of assessment, it appeared that the activity of carrying out assessments with families where drug use was an issue was rarely mentioned. It seemed that at

best practice experience and at worst the lay application of the master status and all associated with it were utilised in interactions with drug-using parents. This suggests the need for more focus on frameworks, guidelines and training where drug use and child welfare and protection are issues. Indeed as Buchanan and Young (2002: 195) have suggested many drug-using parents 'will face a lottery in terms of how they are responded to...because social workers (and other professionals) are at best confused about the issue of parental drug use and at worst moralistic and punitive'.

It is reasonable to expect that by virtue of their training, knowledge and professional competence, social workers will carry out an objective assessment of parenting performance of drug-using mothers unaffected by bias, prejudice or stereotyping. However the literature suggests that often the master status of drug user impacts greatly on professionals' views of their drug-using clients, as noted throughout. It also suggests that social workers will not conduct good assessments of parenting, either of drug-using or non-drug-using clients, without standardised guidelines (Billingham, 1998; Buckley, 1998a; Buckley *et al.,* 2006; Cleaver *et al*, 1999; Harbin & Murphy, 2000; LDTF, 1997). As reported by several women and the vast majority of professional workers, including social workers, it appears there is significant variation in assessments and outcomes. Increasing bureaucratisation, staff shortages and conflicting information appear to impact considerably on the quality of assessment and the interventions carried out with families. Professional workers' knowledge and competence with regard to drug use were argued to greatly affect such interactions.

The guidelines in Britain (DOH, 1999) and the recent assessment framework in Ireland (Buckley *et al.*, 2006) offer templates for assessment of children's needs in different contexts, including where problem drug use is an issue. Others have demonstrated how drug-using parents may be assessed without necessarily using a zero tolerance policy (Buchanan & Corby, 2005; Buchanan & Young, 2002; Cleaver *et al.*, 1999; Mounteney & Shapiro, 1997; Murphy & Harbin, 2000). Findings from this study demonstrated that relationships between drug-using mothers and child protection social workers were fraught, creating much worry among the women. The reported behaviours of social workers and indeed the stated views of several interviewed demonstrated marked similarities to those of social workers in the UK (Adams, 1999; Buchanan & Corby, 2005; Scourfield, 2003) and in the US.

The extent of reported mother/child and sibling separations, many of which may be avoidable or preventable, is far-reaching. On the basis of all accounts, it is perhaps reasonable to suggest that a child-focused assessment framework, that is one that kept the needs of the child rather than the current or past drug use of their parent/s at the centre (Buckley *et al.,* 2006; Cleaver *et al.,* 1999; Mounteney & Shapiro, 1997; Murphy & Harbin, 2000), might lead to a more satisfactory and accurate assessment, with more helpful end results for parents and children.

Many women suggested that asking services and professional workers for help creates increased difficulties for them as mothers. Some workers expressed similar concerns. The majority of women were of the opinion that keeping away from services, maternity, drug treatment, social work and others was the certain way of preserving the motherhood role. These beliefs among women, either currently using drugs, on methadone or drug free, are pivotal to their accounts of drug use and motherhood. Such beliefs may not lead to the reduction of drug-related harm that all services would hope to achieve.

Conclusion

Among all participants, there was virtually unanimous agreement that women drug users were watched and monitored in their performance as mothers and that those watching in an official capacity were professional workers in the drug treatment, social work, nursing and medical fields. The women's interactions with drug treatment services and child protection social work services were the focus of this chapter.

Many women and professional worker respondents identified the role of the services, drug treatment and social work agencies specifically, as those that offered support and assistance to women in relation to their drug treatment needs and parenting concerns. The actions and interventions of such services were described as both caring and controlling simultaneously.

Almost all the women participating had been involved with clinic-based drug treatment services during their drug-using careers. Pregnancy, motherhood, children or their own mothers' encouragement were most often identified as the reasons for seeking treatment. Most women described positive, supportive and helpful relationships with individual key workers in the drug treatment services. All viewed the processes in clinic-based treatment programmes as controlling.

A little more than half the women interviewed had contact with community care social work services. In the main, women participants were fearful of interactions with social workers. However, some of those relationships were described as helpful, supportive and life changing. Whether they achieved it or not, in the main, family preservation was the stated objective of much of the work in which all social workers engaged. Despite this, many women believed that social workers automatically assumed that women drug users are unfit parents. They also believed that the inevitable outcome of interactions with social workers was the loss of the motherhood role, which was why they often determined to avoid contact with them. Significantly, many professional workers, including social workers, concurred with the women's views and beliefs. Indeed, the expressed opinions of some social workers revealed their confusion and uncertainty about dealing with women drug users engaged in parenting.

Ambivalent views about drug use, harm reduction, methadone maintenance and drug treatment were expressed by several social workers and drug treatment professionals. The discussion

highlighted how the lack of information, knowledge, understanding and interagency and inter-professional cooperation with regards to drug issues and childcare can impact on both worker confidence and ability to respond to drug-using parents and the parents' experiences of the services. A typology of workers, based on their approach to and optimism with regard to outcomes for women drug users as mothers - as non-believers, pessimists, pragmatists and resisters - was offered.

The next chapter explores the women's experiences of loss of the motherhood role and their children to the care of others.

CHAPTER SEVEN

MOTHERHOOD INTERRUPTED, TERMINATED OR RETRIEVED: LOSING & REGAINING CUSTODY

> . . . in an ideology which sees women and motherhood as characterised by self-denying and subservient nurturing of men and off-spring alike, should the angels be pregnant or responsible for children, they have even further to fall and fall more heavily. [Waterston, 1996:180]

This chapter recounts the experiences of those women who were unsuccessful in defending their motherhood role, whose careers in parenting were interrupted or terminated. It follows the last chapter, which explored the issue of the surveillance and monitoring of drug-using mothers by professional workers in the drug treatment and social work fields. All the women encountered during observation, in focus group and interviews highlighted the precariousness of their motherhood role and described various challenges to their role as mothers. Many women participants lost their children to the care of others. In total, 15 (57.69%) of the 26 women interviewed reported such a loss at some stage of their lives. Thirteen women (50%) currently had one or more children currently living elsewhere, seven (26.92%) of whom had none of their children in their care.

Loss of custody is reportedly the major challenge facing drug-using women and it is often assumed to be the eventual outcome of the combination of the two careers. Women drug users' children are often taken or placed voluntarily into care at or shortly after birth in the US and Canada (Boyd, 1999; Maher, 1990, 1992, 1997; Murphy, 1992; Murphy & Rosenbaum, 1999) and substance-using mothers involved with the child welfare system are more likely to lose custody than non-using mothers (Grella *et al.*, 2006; Marcenko *et al.*, 2000). While there is less of a likelihood of such an immediate intervention in the UK (Klee *et al.*, 2002), the children of drug-using parents are it seems more likely to be taken into care (Forrester & Harwin, 2006; Howe, 2005; Keen & Alison, 2001; Kelley, 1992) several studies suggesting a strong link between child protection social work and substance use in the UK (Forrester, 2000; Forrester & Harwin, 2006; Hayden, 2004; Rickford, 1996). The voluntary placing of children in the care of others is not an unusual experience for women drug users either (Taylor, 1993). In the Irish context, little is known currently about this phenomenon (Butler, 2002e; Woods, 1994).

While almost every woman participant who had her children in her care feared the loss of their children to others, some experienced this reality. While all the women experienced varying challenges to their parenting role as described in the last chapters, some experienced the ultimate consequence of challenges and the loss of their children to the care of others. The women's loss of

children can be seen as a consequence of their involvement in activities, such as illicit drug use and the associated lifestyle, not normally associated with 'little Irish mothers' (Inglis, 1998).

Firstly, retrospective and current accounts of the women's experiences of challenges to their motherhood role are related, followed by an examination of custody loss and its aftermath. Alongside accounts of those who have lost their motherhood role as a result of losing custody of all their children are those of women who have lost custody or care of one or some of their children. Since some women have retrieved their children or had them restored to them, these second chance experiences are also described.

Motherhood Challenged - Defending Motherhood

While some succeeded in being a mother and doing mothering throughout their careers, each and every woman experienced challenges to the role. Of 205 women participants, all discussed such challenges and many discussed custody loss, the 26 women interviewees describing these experiences at length. Key actors such as family members, partners, former partners or professional workers in the drug treatment or social work fields often mounted challenges at key transitional moments or at points of difficulty.

Women often described themselves as *'surrounded'* by children, families, mothers, partner, community, society, and services and experienced a high level of control on their activities and movements. Many women identified support from partners as well as families and their drug-using and non-drug-using friends. Family expectations, particularly their mothers', and those of professional workers posed considerable difficulties for the women in terms of their drug use, treatment, their relationships with partners, their involvement in parenting and their identity and self-esteem.

Changes in family and partner support, health crises, drug use, and interventions by services over time impacted on the women's motivation and parenting careers. Family supports, drug treatment and social work services often acted as protection against a range of impacts as had been observed in other studies (Barnard, 2003; Colten, 1982; Hogan, 1997; Hogan & Higgins, 2001a, 2001b; Taylor, 1993).

While all the women met during fieldwork believed that they had experienced challenges to their mothering role precisely because of their drug user status, not all experienced interruptions to their mothering careers. Of the 26 women interviewees, ten women parented throughout their drug-using careers without interruption, while another woman made the transition to motherhood after she became drug-free. Eight of these 11 women however who successfully maintained their motherhood role described moments when their role was under review, challenged or at risk. Four described unsuccessful challenges from social workers, while four women, all under the age of 25 years, identified their mothers as challenging their roles. Two described challenges from partners

or ex-partners. Another woman mentioned inundation in drug use and associated life style as the biggest challenge to her motherhood role. At interview, some were experiencing challenges from partners, mothers, and service providers.

While drug use often presented challenges to the women as mothers, frequently the challenges arose from the circumstances in which they lived or from the disapproval of others. Thus, the women employed one, some or a wide range of strategies to defend and preserve the motherhood role. These included consciously deciding to stay away from treatment services, to hide their use, accessing drug treatment, living a straight lifestyle with no criminal involvement,[108] careful choice of partner and father of children,[109] engaging family support, and importantly *'keeping social workers at bay'*. Some ceased all drug-using activity, while others entered treatment in order to preserve their motherhood role.[110] Even so, they all reported experiences of challenges. Protective strategies were employed to protect their role and their children, as seen elsewhere (Barnard & Barlow, 2003; Hogan & Higgins, 2001b; Kroll & Taylor, 2003; Richter & Bammer, 2000; Rosenbaum, 1981a; Taylor, 1993)

Mothers and Other Family Members

The women's mothering performance was watched by family members, particularly the women's mothers, sisters and aunts and in most cases was supported and approved, although at moments their role was challenged. Women drug users' relationships with their families of origin were reportedly difficult or problematic. Almost all the women, with a few notable exceptions, spoke about the support their mothers provided at some points during their lives. Nonetheless, while women acknowledged the tremendous support their families offered, they also acknowledged that difficulties arose in this relationship.

Some experienced the early interventions of family members, several women describing the actions of their mothers, who stepped in almost immediately after the children's births and took over the 'doing' of motherhood. Several women recounted how their first children, born before their drug use commenced, were taken into their mother's care. Others had ceased using drugs and were drug free when their first children were born and yet their mothers took over their rearing. In several cases, the eldest child or even several older children were living with their grandmothers.[111]

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[108] While Brenda was always conscious of the risk of challenges because of her drug use, she stayed away from criminal activities, *'appearing straight'* and also stayed away from treatment agencies. Ellen did not seek treatment with methadone and only became involved with a non-residential drug free therapeutic community day programme. However, she described her own drug use and criminal involvement as providing the most forthright challenge to her parenting. She *'copped on'* and stopped using because of her child. Brenda, Ellen, Frances and their younger counterpart, Sandra, stayed away from services or had very limited involvement in order to protect not only their confidentiality and their reputation but also their mothering role.

[109] While Brenda, Ellen and Marina's supportive partners were also drug users, Frances' partner had no drug history and supported her throughout.

[110] Amy, Ellen, Frances and Katherine specifically identified *'giving it all up'* and becoming drug free as their central strategy while Helen, Jenny, Marina, Wendy and Susie employed entry to treatment as their strategy for preservation of the role.

[111] Three women each had one child, the eldest, in the permanent care of their mothers, one woman's only child and another woman's two older children were in their mother's care.

Many women were aware of their mothers' willingness and desire to become the primary carers of their children.

> *I know in some cases, some mothers like to take control, ... I know that I never let that happen. ... You know their mothers telling them what to do. ... I never had that experience. I wouldn't let anyone mind my child and I still don't to this day.* [Focus Group participant]

Where family members, particularly grandmothers, were often totally committed to almost full-time care of their grandchildren, the children's mothers worried about this and resisted their mothers' involvement. Many felt that their mothers at times interfered and took over their mothering roles, or at least tried to do so.

> *Me Mam keeps sayin' to me when I'm in a fight with her sometimes, you know "Oh if you get your own place you'll probably end up with your kids dirty" and this and that. But I'd never!* [Janet]

It was apparent that for many, their mothers' involvement with parenting their children and indeed taking over that role completely was difficult to challenge.

> *But she wanted him. ... Why did I let her take him? Because she said I hadn't a hope with the social workers because I'd been a junkie, and "once a junkie, always a junkie". I believed her. I was terrified of her.* [Avril]

However, many were convinced that without this support they would have lost their mothering role permanently or failed in their attempts to be a good mother and maintained that their mothers' interventions, while often unwelcome prevented them from losing some or all of their children into non-kinship care.

> *If it wasn't for me mother, I wouldn't have gotten a grip of myself, that I'd still be on the streets, robbin', takin' drugs, not givin' a fuck about me kids, you know, not being a proper mother, you know and I didn't, well she didn't want that life for me and I didn't want it either.* [Andrea]

Where women had lost one child, often the first to the care of their mother, they experienced a lot of difficulties and little support with the care of subsequent children.

> *My mother helped me an awful lot with my first daughter and then my second daughter. ... then when I got pregnant on my last child I took control of him because me mother wanted to jump in and help... I wasn't letting my ma take control of him...* [Emma]

Relatives offered many material supports and resources and assisted with childcare, often playing monitoring roles, in some cases positively protecting children from some of the impacts. They provided crucial emotional support both to the women and their children. Some professional workers and family members viewed family support as enabling drug use (Barnard, 2003; Strauss & Falkin, 2001). Often women's mothers distrusted their daughters and sought to control, monitor and intervene, also noted elsewhere (Strauss & Falkin, 2001).

While families were often helpful, the women's dependence on parents continued, in many cases greatly diminishing their parenting role. Loss of children to grandparents was common enough in this study. Where it had not already commenced, drug use often commenced shortly after a child

was placed with the grandmother.[112] Strikingly evident in several women's accounts was that this infantilisation or redundancy reportedly contributed to the onset or exacerbation of drug use. Conflicts between women and their mothers were common at moments, not least in relation to parenting involvement and style, but also in relation to their male partners. Their children often witnessed or became aware of their grandparents' disapproval of their mothers' parenting and, in some cases, drug use. Children sometimes were placed in a position where they had to negotiate and indeed even manage the difficult relationships, which existed between their mother and grandmother, and in some cases their father.[113]

The importance of the role played by grandparents has been often acknowledged (Barnard, 2003; Colten, 1982; Duggan, 2007; Family Support Network, 2004; Hogan, 2003; Hogan & Higgins, 2001a; Kroll, 2007; Murphy-Lawless, 2002; Rosenbaum, 1981a; Strauss & Falkin, 2001; Taylor, 1993) and is echoed in the present study. However the difficulties experienced in these family relationships have also been noted. The supports provided by families depended on the health and well-being of involved and care-giving relatives and sometimes quick and sudden changes due to poor health, hospitalisation or death occurred, abruptly sending a child or children to another carer. Also noted were the women's descriptions of being infantilised and rendered childlike in their dealings with their children and their mothers, their roles often reduced to that of sister, mirrored in another study's findings about families' impact on drug users' diminished parenting role (Barnard, 2003). Families were often very supportive of their daughters' children but not of their daughters and consequently not supportive of the women's ongoing involvement in parenting.

While many described supportive families, a significant number of the women interviewed experienced a lack of family support or variations in support over time. Significantly only half the women interviewed had ongoing family support and an even smaller number of fieldwork contacts claimed current positive relationships with families.

Without family or partner support, women often had to contemplate placing children in foster care. However, in other situations they lost their children to their own family. Several workers referred to the *'second chance'* experiences for parenting of the women drug users' mothers when they took care and custody of their daughters' babies and children. Indeed, it appeared frequently as if their mothers viewed the births of their grandchildren as an opportunity for this *'second chance'*. Some women suggested they were *'having their children for'* others, for their mothers, sisters or for their

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[112] It is interesting in these situations to note that Janet's opiate use commenced three weeks after giving birth to her first baby at 15 years, while Alison started using opiates in the first year of her first child's life. Darina, on the other hand, became drug free after giving birth at 21 years and while she remained drug free for eight years, she did not rear her first son. Emma became drug free when she was pregnant at 18 years, gave birth and remained drug free for three years. Starting to use again after the birth of her second child, her mother effectively reared both children. Janet, Alison and Darina each have one child, the eldest, in the permanent care of their mothers while Emma's two older children are in her mother's care.

[113] Several of the adult children of drug-using parents who spoke with me during fieldwork raised this very point.

partners, or as they said, *'for him'*. Professionals also noted this phenomenon, one nurse/midwife [W 33] asserting that *'They've had the baby almost for their mother'*.

Many women resided for a period with their families of origin, a finding similar to several studies carried out in Dublin (Flanagan & Richardson, 1993; McCashin, 1996). Some women however reported poor relationships with one or both parents during their childhood or teens. These were reportedly much improved in adulthood, perhaps due to the presence of children. Tensions arose between women and their mothers about how to parent. If motherhood means womanhood/adulthood, tensions appear to emerge between the *'little mother'* and the *'big mother'* or the *'proper mother'* where they live in close quarters.

Tensions in families were often high before the pregnancy occurred, not least due to the women's drug use. Commonly, tensions between the women's mothers and partners arose as they sometimes fought for rights to parent the children and care for or control the women. Their mothers consistently blamed partners for their daughters' drug use and the partners blame mothers for placing obstacles in the way of their fathering and involvement in co-parenting.[114] The women often were obliged to manage the difficult relationships between their mothers and partners. Some professional workers also argued that family support generally was more forthcoming for the children of women drug users and for male drug users, who reportedly experienced greater tolerance from their mothers and families.

Current or Former Partners

Others described challenges to their parenting from former or current partners. Significantly women often talked of conflicts between their partners and mothers in relation to themselves and their children, often causing great stress. In some instances, women felt that they had to choose between mother and partner or in some cases, between partner and children.

> *"Just leave him, he's no good for you". She's after saying that about one hundred and one times. ... Now I'm only now starting to cop on after five years and starting over again. So I'm starting to try and move on with the baby.* [Jenny]

> *I have a two year old daughter now and my mother has never seen her, has never sent her a birthday card, has never asked about the child, has absolutely no contact to do with her whatsoever just because she does not like the daughter's father, do you know what I mean?* [Alison]

Sometimes partners, even while supportive with parenting, undermined the women with regard to their mothering abilities. However, current or former partners often presented actual challenges to the women's motherhood role, thereby controlling the women. While some partners actively

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[114] I spoke with several mothers of women drug users and women's partners during fieldwork and this issue emerged time and time again. Taylor (1993) has documented this in the Glaswegian case as has Murphy-Lawless (2002) in the Dublin situation where she discussed the impact of a daughter's drug use on her mother and family.

attempted to gain custody, other women had experienced regular threats of this. Several women remained in intolerable situations to avoid being challenged by partners.

> *He said that if I try to leave him, that's fine but the baby's staying with him. He says, I'm not taking the baby. So I'm stuck with him and he knows it. He knows I'd never leave the baby.* [Helen]

While several women experienced unsuccessful challenges by former partners, as a result of threats and challenges, four (15.38%) of the 26 women interviewees lost custody of some or all of their children formally or informally to male partners, even in three cases where the men had a drug use history, alcohol problems or criminal involvement. Several mentioned how the choice of a non-drug-using man or a drug-free former user as partner and *'good father'* could backfire badly, as fights for custody using the women's drug history as ammunition were initiated. In almost every situation where men gained custody, they had female relatives or new partners standing by to act as primary carers to the children. Indeed one of the interviewees was caring for the two children of her partner, who had succeeded in gaining custody from his now drug free former partner.

Women were then often denied access to their children. In addition, siblings were denied contact with the sibling in the care of the father in several cases.

> *I'm going to go through a solicitor and a social worker. It's very important for the kids, and for me too.* [Arlene]

Following on from the discussion of gendered expectations in the last chapter, it is notable that the women believed that it was women who should be regarded as the *'proper'* or rightful parent, because they did the practical work of parenting while the *'fellas come and go'*. Several suggested that children, while they may be separated from their fathers for various reasons, should never be separated from their mothers.

> *I think for anybody to take a child off its mother, it's unreal, you know.* [Darina]

As mentioned earlier, partners' involvement in co-parenting or other aspects of the women drug users' lives have merited little attention (Klee, 1996, 1998). Generally, their partners have been discussed in relation to drug initiation and pathways, domestic violence and impact on treatment outcomes (Gilbert *et al.*, 2000; Humphreys *et al.*, 2005; Laudet *et al.*, 1999; Maher, 1995a; Powis *et al.*, 2000; Rajah, 2006, 2007; Sales & Murphy, 2000; Taylor, 1993; Theidon, 1995). However little attention has been given to partners' impact on custody challenges or loss. Significantly, Colten's (1982) research identified those women in her study who had lost child custody as more likely to have been married at some stage of their lives, inferring although not explicitly suggesting partner impact. The experiences of several women in my study, challenged by their ex-partners, men who had often been physically violent to them, highlighted some of the difficulties arising for women with non-drug-using partners whose children have been taken into care. In some cases, interventions by social workers actually recognised these challenges and formalised these arrangements.

Social Workers or Other Professionals

As seen throughout in the findings and the literature, some differing views were expressed by professional workers, including social workers, as to whether drug-using parents, particularly

mothers, are 'fit' to parent. Two social workers highlighted the fact that the majority of women drug users they encountered in their capacity as community care based workers *'were not really OK parents'*, one suggesting that they were

> *Disasters, all of them! Well most of them. Walking disasters! Not able, no insight into their addiction or into the needs of the child.* [Social Worker, W 32]

However, while there is significant evidence emerging from this study and from the literature reviewed in Chapter Two, that many drug-using parents are far from *'disastrous'*, this was the expressed perception of a very small minority of professional workers. Professional workers also claimed that it was a belief often held by family members and used to control the women. Partners and mothers often threatened the women with reports to social workers. Sometimes these reports were made and the women unwittingly become involved in interactions with social work services.

> *His ma reported me cause I wouldn't let her see the kids. So out straight she reported me. And I went up to meet the social worker and she just closed the file. I was, it was just a family fight and she just closed the file. She said there's nothing to worry about and all, you know.* [Marina]

> *I said to him "if you're goin' to mess the kids around I'll stop you seein' them. It's no skin off my nose if you're goin' to mess them up". He said, "Well I'd bring social workers in". I said "Work away. I've nothin' to hide!" But it's my worst fear!* [Katherine]

In other situations, a service such as a maternity hospital, a public health nurse or a drug treatment agency, made referrals to the community-based social work services. Some social workers were described as not being overly concerned about a woman's drug use or treatment as long as the assessment of parenting was sufficient. However others reportedly applied very stringent categories about drug use to the assessment process, as noted in the last chapter.

> *(The social worker) says that ... a good parent wouldn't take drugs ...She says "A good parent will not take drugs or will not inflict themselves under any sort of ... alcohol or anything like that...* [Ethna]

In several women's situations, they perceived that treatment involvement made no difference to the social workers' views. It appeared that judgements were made about women's involvement in activities such as prostitution and that while this did not necessarily impact on mothering performance, this certainly impacted on how women were perceived as parents. The majority of the women believed that they had a 'spoiled identity' as women and as mothers because of their involvement in drug use and prostitution or crime.

> *It was a foregone conclusion that my baby would be taken. So it was easier to make the decision and do the right thing. At least I can say it was voluntary. ... You know, I know I was disapproved of. I'd've never gone back working [in prostitution] if I'd've kept the baby. ... But I knew they didn't want to let me keep the baby. I'm damaged goods. My other kids are in care and I didn't get a chance to prove myself different this time either.* [Elaine]

> *I'm the living proof of the fear that a lot of women drug users have going in for treatment in case something will happen to their children. He left the house and the kids which I don't think was on anyhow...But they never contacted me. .... I would have come straight home. But they were waiting to take the kids!....* [Sharon]

A social worker [W 13], involved with this case, expressed horror at the way the social work team had intervened.

> *It struck me as highly unethical. The father had left them. She should have been offered the opportunity to return home. But the doctors wouldn't let her out. They delayed telling her for twenty four hours and they didn't want to discharge her to go to court the following week. Quite frankly I never saw anything like it.*

While this kind of practice, experience and outcome might be claimed by some other workers to be unusual and represent a negative or minority case (Mason, 2002; Miles & Huberman, 1994), it is important to include this in a qualitative study that aims to ensure that all accounts are included.

While keeping social workers at bay was a common theme, several women recognised the epiphany-like effect of being challenged by social workers as noted in the last chapter. Involvement with illicit drug use led to challenges to the motherhood role and for many women affected their long-term involvement with some or all of their children. Some were aware that their drug use had indeed affected their parenting capacity greatly. However for others, regardless of actual parenting performance, due to perceptions as a risky category of parents, parenting involvement was reportedly often impacted upon simply because they are or have been drug users. This echoes in part the findings of several comparative studies of drug-using and non-drug-using mothers which identified parenting involvement as the only one of three domains in which drug-using parents differed from non-drug-using parents (Colten, 1982; Suchmann & Luthar, 2000).

Many believed that this spoiled identity affected their interactions with maternity services, public health nurses, social workers and other professionals, even long after the drug career was concluded.

Other Crises – Drug Use, Imprisonment, Illness

For some, often later in their drug-using careers, when the chaos, uncertainty and inundation affects their roles as mothers and impacts on their ability to keep it together (Rosenbaum, 1981a: 47), some have been significantly challenged in their mothering roles. While many women encountered challenges to motherhood as a result of their involvement in drug use, several women lost or gave up care and custody of all or some of their children either permanently or temporarily. There were often several reasons for the loss of the motherhood role. Sometimes it was a multilayered experience of difficulties with total immersion in the world of drug use, crime, resulting imprisonment, and often, in addition, homelessness.

> *It's no joke to rear a child on your own anyway but if you add in all the extra things which may be homelessness, which may be drug use, which may be poverty, they're all, that they're all are very tricky and hard situations to be in.* [Social Worker, W 01]

Several women identified drug use as the major challenge to their role and described how their involvement with a drug-using lifestyle, crime and prostitution impacted on their ability to remain in

the role. Some made decisions to leave their children in the care of others as immersion in the life progressed.

> *I'd be coming home in the morning and trying to manage the kids. And without going on too much about it, it was getting harder and harder....I walked out on Dick and the kids.* [Liz]

> *I was on heroin and my second son was six months. Yeah me parenting was bad at that time. I feel today looking back in hindsight I feel drugs just controlled my whole life, that I decided to go to me auntie and I left my son with my aunt and I told her I'd be back in an hour and I left my eldest son with my mother and never showed back for six months. ... She took the book and ran the show ... Me kids are gone out of me life. Not literally took out of me life. It was me making that choice ...* [Andrea]

> *I had to give them up and .... I wasn't going to be bringing them around and letting them see syringes and that. And so I had to. I got time, I got two years in the prison and then my father said "Arlene, you've got to do this, you have to for the children's sake". So because of certain things I went through as a kid with my mother, I decided to do the right thing.* [Arlene]

Significantly the prison experiences of women contacts were also considerable. Many women described themselves as *'in and out'* of the prison system and having lost their motherhood role. A probation officer (W 39) highlighted the tenuousness of the motherhood role for imprisoned women drug users. Her clients' experiences as mothers demonstrated that many children were in the care of others and their access to those children was often limited.

> *They come in, very often aware that they have responsibilities towards their children either in terms of trying to make provision for them if they've been in their care... ...But frequently what we find is because the women having been going through a bad patch before they come in possibly in connection there has been a breakdown in the access.*

Women feared imprisonment as they believed that reunification with their children on release was unlikely. Attempting to maintain their contact and connections with their children and families while in prison, they described experiencing a different situation to their male counterparts who generally were not the primary caregivers of the children. Some women strove to manage the care of their children and their caretakers from within the prison. However despite their efforts, some of these relationships broke down over time and contact diminished. It was particularly evident that those who worked with women incarcerated repeatedly or over longer periods reported the motherhood interrupted or terminated experience as common. The women's experiences were similar to those reported in other studies (Boyd, 2004; Enos, 2001; McCann James, 2004). One author writing about women in prison in the US significantly described imprisoned women as 'mothers on leave' (Enos, 2001: 134), while another Irish commentator (McCann James, 2004: 218) named the experience of imprisoned mothers as 'motherhood adjourned'. Without a doubt, those women in my study who had been repeatedly incarcerated or had spent long periods in prison found that their motherhood role was impacted upon, almost certainly compromised if not interrupted or terminated. They were rarely mothers on leave enduring adjournment until their release. Many women met during fieldwork, one woman interviewed and several workers interviewed made reference to the long-term impacts of repeated imprisonment. The women's identity and status of mother was also

affected, many finding that courts and other systems then treated them as childless or non-mothers even where motherhood was still important in their lives. For those who offended but presented at court as mothers, they often found the judicial system took their role, status and identity on board and were less likely to incarcerate them, as observed elsewhere (Heidensohn, 1996). However, when they were no longer responsible for their children's care, they were reportedly treated differently.

Several women's health was a key factor in impacting upon their motherhood role. The presence of HIV related illness has been found to be an issue affecting mothers' continued residence with and ability to care for their children (Pilowsky *et al.*, 2001), exemplified by Rachel's experience, whose five children were in the care of other family members, her mothering role interrupted due to illness.

> *You see they wanted me to put them into care but I wouldn't. No way would I let my kids go into care. In anyway the social welfare wanted it because of me healthwise. But me Ma said no and I said no! ...I was in and out of hospital that much so we decided that the kids would go to me Ma, me brother and me aunt. But I see them everyday. I'm still their mother. I make the decisions.*

There was consensus that a range of issues other than drug use impact on abilities to parent or mother. Sometimes the women themselves suggested that they were actually stable in their parenting while using drugs but had become less stable as a result of a reactive depression. One woman described her *'total nervous breakdown'* while on methadone. With the support of her then drug-using partner, she coped.

> *Do we, can we actually recognise when we have run into difficulties and do you really know when you can't cope and it's time to ask for help?* [Darina]

Debilitating illness, mental health difficulties and repeated hospitalisations compromised the ability of several women to provide consistent care and they had to make alternative arrangements for their children. In other situations participation in residential drug treatment programmes necessitated that children be placed in the care of family members or foster care. Many women worried that their children would not be returned to their care following these programmes, some of which were lengthy in duration. Homelessness and Bed & Breakfast (B&B) accommodation often motivated women to consider asking others to provide shelter and care for their children. In some cases, drug use and imprisonment were the precipitating factors. Many women who sought alternative care for their children from family members while they were using drugs, found that reunification with those children rarely occurred on entering treatment or becoming drug free.

Like the women in Taylor's study (1993), asking for help and support was seen as a risk. Indeed the women in this study perceived it as a sign of weakness, of not being able to cope and of being unfit to parent. Despite asking for assistance with a range of issues many found little support and interventions forthcoming, particularly with regard to homelessness.

Homelessness

> *... when you look at a state policy of evicting somebody on the basis of very little evidence of something that is called anti-social behaviour, but also that they have children as well, I think that that's really an incredible development. ... what the children were accused of I don't know.* [Social Worker, W 23]

> *I think people who live in poverty their children are a worry to them. They don't have a chance to enjoy them. ...It's just that the experience and the pressures of life as it is at the minute and the coping mechanisms that they have. At one level you could say they're bleedin' brilliant to live in a B&B and have five kids with you and then at another level then you say "No! They're not great at all". Cause I don't know how I'd be able to respond if I was with five children in a B&B and I had no money, do you know?* [Community Drug Worker, W 38]

Homelessness proved to be a significant challenge for several women. Some studies discovered the importance of a home in the woman drug users' lives (Galaif *et al.*, 1999; Rosenbaum, 1981a; Taylor, 1993; Waterston, 1993, 1999), while the importance of secure and safe living arrangements in terms of reducing drug related and other harm was stressed in another overview of several studies (Maher *et al.*, 1996). However, few have focused on the impact of homelessness or insecure accommodation on parenting. This section will briefly describe some of the experiences of women who encountered homelessness, were challenged in their parenting roles by homelessness and encountered the difficult choice of relinquishment either to kinship or foster care. Almost every professional worker expressed concerns about this issue.

> *It's just a case of women struggling to keep their families together and I mean you have women trailing the streets with three children under the age of 8 with B&B accommodation in the evening. ...* [Medical Practitioner, W 29]

Many respondents emphasised how these crises impacted upon parenting and children.

Almost all woman encountered during fieldwork had experienced homelessness or being out of home at some stage during their lives. Even where women were housed, that did not allay fears of future homelessness. The majority of women identified themselves as impacted upon by the issue of homelessness, whether they in fact were currently out of home or not.

Few ever had slept rough while children were in their care. However one woman described this experience following eviction.

> *I nearly died. Here we all were settling down for the night and it was still daylight. At least it wasn't very cold. We slept in front of the Corpo, you know, opposite the Liffey. The kids thought it was a great gas. ... you stand out with children though.* [Sharon]

None of the other women who were sleeping rough had children in their care. Two of the three women living in B&B accommodation were currently caring for children. Many of the women met during fieldwork were living in B&B accommodation with children.

Several women voluntarily placed their children in the care of others because of homelessness and their feelings that B&B accommodation was inappropriate for the care of children in the longer term.

> *It's no life and I signed them over voluntary ...till they have a proper roof over their heads... You know we just couldn't have them sleeping on the street beside us. ...I just felt I had no choice. I was sick dragging them from a B&B to a B&B and back again.* [Sharon]

> *The three of them were with me in the B&B but I gave me young fella to my sister to look after cause he was just wired there and I thought we was going to get thrown out on our faces.* [Maeve]

Others hoped that in the long-term they would access accommodation before they had to consider such an action.

> *I've been on homeless list and me worker is helping me so I hope it'll be OK. I don't mind living there, it's better than sleeping out or in a hostel, you know. But when I talk to some of the other girls, they say they've been there for years and I think "Oh God". I don't mind it for a while. But hopefully, please God there'll be an end in sight.* [Sandra]

Many respondents repeatedly raised a large number of key issues with regard to poverty and homelessness. Sleeping rough and the difficulties of doing so with children, separation from partners, lack of companionship and lack of support with parenting, the level of visibility while with children on the street were just several identified. The difficulties of feeding children, reliance on take away foods and the difficulties of ensuring that children have regular eating times presented concerns for the women living in temporary, cramped B&Bs and hostels. Many women mentioned the difficulties experienced with proprietors of B&Bs who did not permit them to mix with other residents and complained constantly about the noise and mess that children sometimes make.

Major concerns and reservations were expressed about the suitability of such housing for children. Treatment, school attendance and social, community and familial support were more difficult to organise and access when living in B&Bs. Respondents discussed their observations of babies and children who were living in B&B and hostel accommodation. Some worried about the children's inability to crawl due to lack of space and difficulties with toilet training because of lack of facilities during the day. One doctor observed several children who in his opinion were not reaching developmental milestones at the appropriate times as they were lacking a range of necessary stimuli. The mothers also expressed these fears and concerns. Several workers aptly described the challenges, believing that parents are

> *to a certain extent, set up to fail in their parenting, or they're set up to be kind of labelled as poor parents, particularly parents in hostel accommodation who may be regarded as having failed to provide their children with adequate shelter and accommodation.* [Social Worker, W 26]

Others talked of how the women *'just can't hack it'* [Nurse/Outreach Worker, W 10].

Many fieldwork contacts were not currently caring for their children and spoke at length about their children being in the care of others due to homelessness. Many of them, now stabilised on methadone and several drug free, asserted that it was hard not just to leave a drug career behind but impossible to leave the stigma of a drug history behind in the eyes of family, community and services. This affected their opportunities for accessing accommodation. The experience of one

young homeless woman whose child was at that time living with the paternal grandparents was described as *'living proof of this'*. While her drug use was stable and all workers involved were of the view that her parenting was appropriate and skilled, her lack of stable accommodation meant that her child had to remain with paternal relatives. The longer he remained in their care, there was less possibility of reunification, as observed in other studies of the children of drug-using parents (Akin & Gregoire, 1997; Besharov, 1990; Carten, 1996; Fanshel, 1975; Kovalesky, 1997, 2001; Kovalesky & Flagler, 1997; Regan *et al.,* 1987; Smith, 2003; Testa, 1997).

> *There's all this energy being put into case conferences and the clinic about her drug use, about her drug programme, about her rehabilitation but there's nobody really helping her to access decent housing that would allow her and her child to live together.* [Social Worker, W 01]

The implications of homelessness for a woman's ability to parent her children were considerable. While struggling with some of the issues discussed above, women also reportedly had to deal with a range of perceptions among professional workers concerned with child protection.

During fieldwork, many topics were discussed with 205 women at various stages of their drug-using careers. Almost all expressed grave concern about the Housing (Miscellaneous Provisions) Act, 1997. While some professional workers described this particular piece of legislation as *'an anti-woman law'* or *'an anti-family law'*, others argued that family members and communities have a right to defend themselves and have done so to protect their homes, families and children. This Act, which introduced measures designed to address problems on estates arising from 'anti-social behaviour', such as drug dealing, however, has impacted on families who have a drug-using member living with them or on families where one or both parents are or have been drug users. Many were concerned that the threat of homelessness because of their drug user identity was ever present. However, for some as seen above, homelessness presented major difficulties, impacting on themselves and their children. Consequently, motherhood was sometimes interrupted, the children separated from their mothers and often their siblings.

In summary, the 'three P's', illness, imprisonment, drug use and homelessness all presented major challenges to the women as mothers, in the face of which they employed a range of defensive, compensatory and protective strategies with various outcomes, observed in other studies (Barnard & Barlow, 2003; Hogan & Higgins, 2001b; Kearney *et al.,* 1994; Kroll & Taylor, 2003; Murphy, 1992; Murphy & Rosenbaum, 1999; Richter & Bammer, 2000; Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993).

As reviewed earlier, several studies identified the characteristics of those who succeeded in maintaining custody of their children (Knight & Wallace, 2003; Meier *et al.*, 2004; Pilowsky et *al.*, 2001; Schilling *et al.*, 2004). Those who use drugs less often and chaotically, enjoy better health and live in less adverse socio-economic circumstances tend to be more successful in this regard. Such findings resonate with those reported here. In addition, despite the reported challenges presented by the tensions, difficulties and differences that emerged between the women

participants and their families around the care of their children (Barnard & Barlow, 2003; Hogan & Higgins, 2001a; Kroll, 2007; Laybourne *et al.*, 1996), those who maintained the role tended to have more family support, both formal and informal. Their children had the benefit of grandparents involved in their care, as was also noted elsewhere (Barnard, 2003, 2005b, 2006; Dumas, 1992; Hogan & Higgins, 2001a). In this study, women who experienced less family or partner support, homelessness, frequent or long-term imprisonment, poor health due to HIV infection or engaged in frequent and chaotic polydrug use were more likely to be challenged as mothers and were also more likely to have lost custody of one or more of their children as discussed below.

Losing Motherhood

Despite the defensive and protective strategies employed to fend off challenges to the motherhood role and to care adequately for their children, many women experienced custody loss, formally or informally. The responses of services were often to intervene with mothers using drugs and to suggest alternative arrangements, as described by one social worker (W 26).

> *It doesn't matter how many times they hear that it's not the drug use per se, they hear drugs they go ape. Many of the women are persuaded to put the children voluntarily into care or to go with family situations.*

So what happens when mothers place their children in the care of others or have them removed from their care? What happens to the women? What happens to the children? Although there is some evidence from other locations about custody loss among drug-using women and the impacts on both the women and children, to date little is known about this experience here in Ireland.

Fifteen women experienced loss of some or all of their children, only three of whom later retrieved their role and their children to their care. Workers continually made reference to and stressed this possibility for women drug users. While the status and identity of mother remained and was often guarded carefully by the women, their opportunity to do mothering, their role, was given or taken away.

Significantly many women asked for assistance from families or help from services, which often led to painful decisions about the care of their children. For some drug-using parents, their children going into care of others was a *'turning point'* in their lives, described as an epiphany. However, most of the women and workers' accounts highlighted the few opportunities for mother/child reunification and the increasing inundation in a drug lifestyle following custody loss.

Accounts were sometimes contradictory, where choice and lack of choice were mentioned almost simultaneously. Women spoke of giving up attempts to defend their parenting role. It had become too difficult to continue the performance, the defensive behaviours, and the attempts at justifying their role. There was *'no point in going on'*, *'they're eventually going to get me'*. On the other hand some women, particularly those experiencing homelessness and the *'B&B treadmill cycle'*, spoke of having had *'no choice but to do the right thing'*.

The women distinguished between *'voluntary'* arrangements and having a child *'taken'* into care. Several women drew on a discourse of choice and personal responsibility in explaining that they voluntarily placed their children in care *'for the children's sake'* or that they were *'doing the right thing'*. Placing a child in care voluntarily was represented as keeping control, making the decision themselves. However, neither the term 'giving a child into care' nor the term 'relinquishment', used in the US literature, reflect the experiences of passivity or powerlessness described by many women in this situation. The majority, while emphasising that their children were in care as a result of a voluntary arrangement, expressed feelings of powerlessness in this regard.

Women spoke of *'giving up'* attempts to defend their parenting role. One woman differentiated between her first and second experiences of losing her children and motherhood role. She described her experiences of social services' removal of her children into care on one occasion in the early 1990s. Having worked to retrieve her children from care, she later made the decision to place her children in care again due to the family becoming homeless in the late 1990s.

> *At least I know this time I did it because I was not capable of looking after them, dragging them from B&B to B&B. It wasn't fair on them. If I couldn't put a proper roof over their heads, I was prepared to do that and that's why I did it then.... it was hard to make it. Believe you me it was. It killed me but I just thought they'd be better off ...They are better off. They're doing so well for themselves, you know.* [Sharon]

Another woman, Elaine, spoke of her children variously being informally placed with her family, being taken into care and voluntarily placed in care. Their accounts of social services' removal of children into care on occasion and their roles in placing their children in either kinship or non-kinship care due to homelessness or lifestyle issues highlighted the different experiences.

Where children were removed, the women had no choice. However, significantly many workers talked of the importance of convincing women to place their children in care, sometimes with the promise of regular access, increased support, further advocacy in terms of housing and drug treatment, early and easier reunification with children.

> *Many of the women are persuaded to put the children voluntarily into care or to go with family situations.* [Social Worker, W 26]

The women were often persuaded to follow this course of action by family members, partners, and social workers. In the main it was regarded as easier for all concerned if the women made the decision to *'generously'* place their children in care rather than the social workers having to make decisions to remove children. These experiences were almost always presented to the women by others and described by the women themselves, as temporary interruptions to motherhood but often in reality they meant permanent termination of the motherhood role.

Several women identified giving children into care as evidence that they were *'good mothers'*. In their opinions, *'good mothers'* recognised that they were currently, temporarily or even permanently unable to care for their children. They felt that placing a child into the care of others was a success

in itself. Others[115] described how they were encouraged to *'do the right thing'* by family members or social work services. The women spoke proudly about children in kinship or foster care situations, some believing that they had done something useful in voluntarily placing a child in alternative care. Others felt they were *'bad mothers'* for leaving their children although they felt that it was the best outcome for their children.[116]

> *But no, I just thought it was the best thing. It killed me. I went into a depression but I snapped out of it. I just said there's no point until they have a proper roof over their heads.* [Sharon]

One social worker (W 32) also noted this phenomenon, describing the *'incredible generosity'* of one of his clients as she made the decision to place her child in care.

> *She got so many chances, so much work done! Really was, I think, a loving mother, I mean there's no doubt that I believe she loved her children. But by God she did them damage except she was very generous. She let one go into care ...and even though it broke her heart she was able to do this. I remember her saying "I know I can't give him what he's getting".*

Placing children with families informally was the women's preferred option. Many workers favoured this option, although with some reservations. Four social workers highlighted the scarcity of foster families. With the need to call on family members to provide long-term care for children, improved payments to family members involved in alternative caring were introduced. *'Section 36s'* allow for the funding and recognition of some kinship care arrangements. These improved allowances were of course very necessary. These supported arrangements, however, have heralded new difficulties. Sometimes families do not meet the criteria for assessment as foster parents, which creates real difficulties for the families and children.[117]

In other situations, as reported by a number of community care social workers, families were now with increased payments even more motivated to keep the women's children in their care and were less motivated to support the women to retrieve their role.

> *I do sometimes say "How are we going to get these kids back?" you know. Honest to God! Don't get me wrong, of course they should be paid. But I have about three families. And I know that because of them payments we will need to surgically remove those children. ... There's a lot of undermining of the women. Like "see her ...!" They never have a good word about the mother and I do think we're never going to get the kids.* [Social Worker, W 31]

These findings confirm the women's views and experiences. Family members' involvement in fostering, formally or informally, can lead in some cases to undermining parents' contacts with and access to their children. Women's parents or families often wanted to care for their children but wanted little or no interaction with the parents, noted in other studies (Barnard, 2003; Colten, 1982;

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[115] Encouraged by her father to *'do the right thing'*, Arlene placed her two daughters, now teenagers, in care as toddlers and Elaine placed her young baby, her fourth child, in foster care during the fieldwork period.

[116] Andrea left her children with her mother and aunt for a period while she was homeless and using street drugs, while Liz felt that she was a bad mother for leaving her children with her husband, she actually believed that her delaying visiting her children was the action of a good mother, doing it *'for their good even though my heart was breaking'*.

[117] Documented in a report from Citywide (Family Support Network, 2004)

Hogan & Higgins, 2001a; Taylor, 1993). Many women found it difficult to retrieve their children from their mothers and their children often stayed with family members for long periods or permanently, echoing suggestions in some US research that reunification rates were slower for children of drug-using parents in kinship care (Smith, 2003; Testa, 1997). However, the women believed that private and voluntary arrangements with family members were better than formal non-kinship foster care arrangements and two women, who successfully recovered their motherhood role, retrieved their children from this situation.

Motherhood Interrupted – the Aftermath

The loss of custody, temporary or permanent, had far-reaching effects on the women and their children. Women and workers discussed at length the fallout from the loss of children into the care of others. Two key issues emerged here, the first in relation to increased illicit drug use among women who have become non-custodial mothers and the second, with regard to ongoing contact with and access to the children. In this study, exacerbated alcohol and benzodiazepine use, drug taking and further immersion in street life, homelessness, mental health difficulties and loneliness were often described and observed among women, particularly those met on the street. These repercussions in the wake of the loss of motherhood, described by women and workers in this study, confirm other research findings highlighting the consequences of loss of child custody (Kovalesky, 1997, 2001; Taylor, 1993).

Many respondents recounted how the women's grief was ignored and unacknowledged, attempts at reunification were often unsuccessful and ongoing attachment, relationships with and access to the removed child or children was affected adversely. Several workers mentioned that there was a belief or perception that women were sometimes satisfied to have been relieved of the task of parenting, their children described as *'burdens'* to them. However few, if any, of the women described their children as burdensome although the roles of housekeeping and managing poverty were often regarded as such.

Interviews with women, whose children were no longer in their care, revealed their sense of loss and hopelessness. The experiences and accounts of the women and professional workers provided evidence that women drug users *'give up'*, are undermined or espouse a negative view of their parenting skills. For those remaining separated from their children, a process of motherhood mourned, regretted and longed for continued. For some, this *'failure'*, *'redundancy'* or *'loss'* meant that other family members, usually their mothers and sisters, acquired the parenting role. Hence these relatives became the *'good mothers'* while the women felt they had achieved the status of *'fallen women'* and *'bad mothers'*, echoing many other studies. These occurrences reportedly had far reaching effects on the women but, as suggested by some international studies, may impact greatly on the removed children and their long-term outcomes (Kovalesky, 1997, 2001).

Contact with and access to children in kinship and non-kinship situations have also caused major crises for non-custodial mothers. Following interruption, the women tried to mother on either a part-time or occasional basis through contact with their children at their mothers' or sisters' homes or through access visits. Doing part-time mothering depended on the willingness and cooperation of others to permit regular contact, visits or access to their children. Family members and former partners may have a significant effect on limiting and even preventing all contact between children and their mothers, particularly if with the paternal family, where there has been an estrangement. For women whose children lived with family members, there were the added concerns about their children's knowledge and understanding about their care arrangements. This concern was raised by several social workers. Some women did not wish for their mothers to raise their children in the same way they had been raised.

Hence access visits and the period following these were often sad and lonely periods for women. Many of the women believed that foster mothers were afraid of them.

> *She doesn't like drug users. She doesn't want me seeing me kids. So little by little each time there's a cancellation. If I cancelled visits then I'm not motivated as a mother. But them they're always cancelling visits. After a while you do just give up.* [Elaine]

This in fact was not an isolated view. Several social workers also acknowledged that foster parents were often very anxious about drug-using parents.

> *Certainly like I have a lot of contacts with foster parents and they would all have a big issue about drug users, you know, the perception that drug users are violent, aggressive, on heroin...* [Social Worker, W 37]

The women often were not able to determine when, where, how, how often and for how long they had contact with their children. They recounted unpleasant experiences of meeting their children in often dirty and unwelcoming community care offices or taking children to a fast food outlet where there was little privacy and where expense was an issue. Whether these access visits were supervised or unsupervised also created tensions between the women and their children, their relatives, their children's foster carers and their social workers.

Therefore, some children in alternative situations reportedly saw their mothers, fathers and siblings regularly, even daily, while others saw their families at very irregular intervals due to significant problems with access which was an issue mentioned in successive interviews. In several cases, access occurred at best monthly, if at all.

Additionally, many women were concerned about the effects of their visits on their children, as were several social workers. Many saw their children less frequently because of the upset to themselves and their children.

> *Taking children into care is definitely not the answer. Taking a child into care has got to be the absolute last resort.* [Social Worker, W 37]

It can suit foster parents, less hassle for foster parents, less work for the social worker. [Social Worker, W 26]

There is no doubt that over time while children of the women were in the care of others, contact diminished and visiting often became more and more infrequent, also seen among women in other studies (Kovalesky, 1997, 2001; Kovalesky & Flagler, 1997; Smith, 2003; Testa, 2003). Some workers and women suggested that the care plans made initially were abandoned as soon as social workers *'got their way'* and children went into care. Several workers suggested that the women were *'betrayed'* and contracts and care plans *'not honoured'*. Sometimes women were undermined by former partners, partner's families, and in some cases, foster carers. Access visits were often discouraged by the children's current carers and in some cases, social workers. Many quickly lost contact with social workers, who had been supportive while their children were still with them.

Having another child after losing a child into care was common, confirming the findings of other studies (Enos, 2001; Kovalesky, 1997; Rosenbaum, 1981a; Sterk, 1999a). Ten of the 15 women (66.66%) who lost their children to the care of others, had further pregnancies, often following closely on the loss of another child. One woman had six further drug-involved pregnancies following the loss of her eldest children into care, while another became pregnant again on each occasion she lost a child to care. Other women intended to become pregnant again, some wanting to wait until they were stable and drug free.

But if I ever get me shit together I'll have another baby and I swear to Jesus, she (her mother) *and no one else will get near that baby!* [Avril]

Women met during fieldwork also described this experience. Indeed their rejection of abortion, adoption, fostering and challenges to their motherhood role, alongside their attempts to retrieve their lost role, revealed the extent of their commitment to motherhood, echoing the experiences of other working-class Irish mothers (McCashin, 1996).

Few people in the women's social networks regarded this experience of interrupted motherhood as a loss or bereavement, merely viewing it as a consequence of the women's behaviour, as reported by women and workers. People often regarded them as *'failed mothers'* or *'bad mothers'*, as several women also believed themselves to be. Many women, custodial or non-custodial mothers, sensed their failure as mothers. Some, by virtue of their involvement in drug use at some stage of their lives, believed that they had *'failed'* to be *'proper mothers'* or *'normal mothers'*, to meet the standards, their own, their mother's, society's, for motherhood. However, for several no longer parenting their children, this feeling of failure was total, some describing themselves in negative and self-loathing terms.

I'd fucked up royally with the children. [Liz]

When their kids come into care it feeds into their whole self-loathing, that they just are totally useless and the system can enforce that or not, you know. [Social Worker, W 37]

Partners' anger, family embarrassment and their children's rage provided further challenges for many women. Often children returned later with questions for their mothers, questions that they often struggled to answer.[118]

Most of the women with children in care expressed concerns about placements that have broken down or when siblings have been separated. Professional workers too mentioned the impact of separation from parents and siblings, as did several children of drug-using parents informally interviewed during the study period.

> *They're put in two different homes. And I worry about that cause they need to be together. They're very close and the little one looks up to the big fella. I think they're lonely for each other.* [Ethna]

> *All my kids are in different places. I think it's a sin. But that's never gonna change, you know.* [Elaine]

Few challenged the actions or care plans of social workers and those who did so, rapidly abandoned the fight against social services as the label of non-compliant or uncooperative was most injurious in the longterm. Indeed it has been argued that social workers and drug treatment professionals are often confirmed in their negative attitudes, stereotypes and beliefs about women drug users when they see defensive and oppositionary behaviours (Murphy, 1992; Murphy & Rosenbaum, 1999; Sterk, 1999a; Taylor, 1993). Where there is intervention and women are reluctant to cooperate with services or social workers, this is automatically regarded as negative (Scourfield, 2001, 2003) rather than determination to defend and preserve their motherhood role and protect their children from attempts to remove them. The automatic assumption that children were better off away from their mothers was believed by many, women and workers, to exist. It has been noted in one extensive review of the literature with regard to parental drug use that it is often unclear as to whether placement decisions about children being placed in out-of-home care stem from the difficulties experienced by children or parents or from society's attitudes to parents who use drugs (Tunnard, 2002a: 22).

One psychiatrist (W 29) talked about how *'broken parenting lines'* and separation present risk to the children concerned. Several women, however, themselves believed that their children would benefit significantly by being raised by others. Most women with encouragement voluntarily placed their children and as a result it was often perceived as something they wanted to do rather than something that others wanted them to do.

Voluntary care arrangements were perceived by the women as the inevitable outcome of interaction with services, particularly social work services. If they refused to relinquish the care of their children, care proceedings often commenced or were threatened. Many saw their children

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[118] Again this was an issue raised by several of the adult children who had experienced separations from their mothers. One young woman, who had been in foster care from eight years of age until adulthood, now had regular contact with her mother and while she *'love*(s) *her to bits'*, at times she felt anger because her mother later had more children who stayed with her.

less frequently because of the upset to themselves and their children. Sometimes contact was limited because relatives or foster families did not favour or encourage access visits. They were not facilitated with transport, funding and premises in which to meet and spend time with their children.

Some women, whose family members were caring for their children, were concerned that they and their mothers or sisters were not getting sufficient support, a very real concern for the families so affected (Barnard, 2003; Duggan, 2007; Family Support Network, 2004; McKeown *et al.,* 2006; Watters & Byrne, 2004).

> *Me Ma's their legal guardian and I have no social worker for my children. I had got a social worker. Well it was the kids' social worker, do you know what I mean? But when she left there's not enough social workers in anyway...For me Ma's sake, the social worker was support for her, for the things she was entitled to.* [Rachel]

Others believed that they were working alongside social services to achieve reunification. Several women had stabilised on methadone or become drug free. However this did not guarantee their preserving or retrieving child custody as homelessness, illness and other issues predominated. Notably none of the women who lost custody were drug free when their children left their care. Some attempted to become so and succeeded in their detoxification attempts. However, after a period where reunification did not occur, they all relapsed.

Alcohol consumption and/or drug use generally increased. For those who lost their children, giving up on reunification, using increasing amounts of mood-altering substances such as heroin, cocaine, alcohol and benzodiazepines and further immersion in the street scene often occurred.

> *Now they're gone, I'm drinking. Both of us started drinking like fish. ...it's a bigger problem now than the drugs. The social workers are all worried about that now.* [Sharon]

This was noted particularly by a social worker (W 31) working in a community care team who identified increasing alcohol and benzodiazepine use as a problem both arising out of homelessness and lack of support in some cases and contributing further to the childcare problems in others.

Accounts of second chances were rare. Only two women interviewed were reunited with their children. None of the women interviewed or met during fieldwork were reunited with their children during the research period.[119] Many were despondent about the future, believing that their children will remain in care.

> *My ma will have him for ever. I don't see that changing. She'll never give him back to me.* [Avril]

> *I'll never be seen as fit. All the kids are gone now. I really thought with the baby they'd give me a chance. I know I didn't have a place to live but a lot of them with babies are put in B&Bs. They wouldn't hear of it. They keep telling*

[119] Two women were reunited with their children since the end of the fieldwork period.

me I'm very good to have made this choice. But it wasn't a fuckin' choice. I hadn't a choice. [Elaine]

The study's findings about drug use, homelessness, illness and crises confirm findings in other locations that non-custodial parents have often been found to be those with the greatest range of difficulties (Meier et *al.,* 2004). Several women who aimed to have their children back in their care believed that they knew what they have to do in order for this to happen.

> *That's all I want in life, three little things. ... my head sorted out first. Then I can look forward to my children, to bringing them to a home where they have their own hall door key, come in, sit down, do what they want to do and just know it's a home.* [Sharon]

Whereas the distinction between doing mothering and being a mother is often made (Enos, 2001; Goode, 1999), those who lost their children still regarded themselves as engaged in doing mothering, even if limited to occasional contact and access visits. It has been documented that women who lose custody view themselves as total failures as women and mothers (Kovalesky, 1997; Murphy, 1992; Rosenbaum, 1981a; Sterk, 1999a), often hiding the fact that they were mothers (Goode, 1999). While some sense of failure existed for those who lost custody of their children, the total sense of failure described in other studies was not evident here, several women identifying their giving up their children as the action of a good mother, one who has insight into and understanding of her children's needs. A different phenomenon was evident among the women drug users who no longer had custody in Dublin, setting them apart from some of their international counterparts.[120] Despite their lost role, some held on to the belief that having become and been a mother for a time, however short, represented achievement and success. Sometimes the women worked towards recovering their mothering role. Several succeeded and these *'second chance'* experiences were described.

Motherhood restored/retrieved

> *I thought at this stage "If I had one chance to get my life, my kids".* [Liz]

While many women anticipated that they might get a *'second chance'* to parent their children in the future, some described how they had a variety of second chances with their children and their motherhood role. Two women reported how they had recovered their motherhood role and had all their children returned to their care. Since the end of the fieldwork period, one interviewee and one fieldwork contact have also recovered their children.

For those who retrieved the role, it was generally family members who had *'held the fort'* and *'kept social services away'*.

> *I took me kids back. I'd decided that this was what I was going to do, go for methadone, get my life and home around me and concentrate on the kids. It was the most important role, do you know what I mean? I'd've never have*

[120] Generally their self-definition was as mother and they almost immediately revealed details about their children not in their care. Their determination to be involved in this research project because it was concerned with motherhood was evident.

given it up to the social services but I knew me Ma would look out for us and she did. I think though she'd've preferred if I left one of them with her. She was always at me "At least let me have Conor. Leave him with me". Me poor Ma, I love her dearly but she does butt in! I can never thank her enough though. But I says "No", I says "They're my kids, I have to do this, they're mine. I brought them into the world. I have to take responsibility for them". [Andrea]

I made contact with them again eventually. But it was them years later who started to ask about coming to live with me. Once they discovered I was (HIV) positive, that was it! They were at me all the time about living with me. But they wanted to come back ...maybe it's to make up for lost time ... We had to straighten all this out. I'm the mother. I care for them. It's settled down now. ... My own mother has been very supportive, I have to say, even with all her nervousness. It was more about protection for the kids. But I think that she really did appreciate, being a really good mother herself and knowing the person that I am and also having the kids and having their best interests at heart. She did know how important it was for us to be together and to be able to be together and to be helped to be together. ... when she saw that I was determined to go ahead with the move she was very supportive there. [Liz]

Both women who retrieved their roles and children recognised that they were privileged to have been able to do so. Their families effectively had taken over the care of their children when their drug use became increasingly problematic. But most importantly, their families were then prepared, if somewhat reluctantly, to permit the children back into their mothers' care. Family involvement in both cases also meant that social services had no involvement with either woman or her children. Many of their contemporaries were not successful in this regard and they were painfully aware of the despair and sorrow of some at separation from their children.

If a woman with kids asked me what she should do, I'd say "keep it hidden, try and detox yourself, stay away from services, keep mum about your drug use". I know that sounds irresponsible of me and me in recovery and drug free. But you know I only escaped and kept me kids by the skin of me teeth. [Andrea]

Another woman, who had long-term involvement with social services lost and retrieved her role on one occasion, achieving her second chance. However she encountered problems later and placed her four youngest children into care again several years ago. She hoped that she might get a third chance. However she believed that initially asking for help from services and becoming *'known to them'* opened her to increased vulnerability, monitoring, surveillance and eventual loss of her children to care.

I often think how it might have been different. Obviously if I'd asked the doctor for help with the post natal depression instead of chasing the dragon, that might have been better! But you know to this day I think the moment I walked in them doors of the treatment centre I was in trouble. I should have sorted it out myself. [Sharon]

Such beliefs among women participants about the impact of asking for help were also noted earlier. A majority of those encountered during this project suggested that *'being known'* to services creates increased difficulties for the motherhood role. The implications for harm reduction, reducing drug related harm, are considerable, an issue which will be visited in the final chapter.

While others did not successfully retrieve their role on a full-time basis, several managed to rebuild their relationships with children who had been placed in care. They regarded themselves as

involved in part-time or occasional parenting. Children have come back as teenagers or adults and sought their mothers out or some deliberately pressurised their mothers to resume their parenting role on a regular basis.

> *I took her on holidays when she was 13 to Butlins…I think the only reason he let her come was because (my sister) was coming with us….And like, meself and Karina are like that now*! (shows entwined fingers) *We've a great bond. All that shit that happened is forgotten, you know. …She leaves her children with me. She trusts me with her children!* [Laura]

> *I mean, the kids will go home. These kids are in foster care till we're finding at twelve or thirteen they're going, they're coming back…. So to take them away and not have access is just cracked.* [Social Worker, W 37]

> *There's also another thing that a lot of them want to go home and make up, this is really contradictory, but to make up for the fact that they were in care because a lot of them feel responsible themselves, a lot of the children and they go home to compensate.* [Social Worker, W 32]

Many also experienced pressure from their children to maintain the relationship and receiving this sort of affirmation, approval and in some cases forgiveness from their children has been inspirational for them. Others, women met during fieldwork, have sought their children out and worked hard to have trust restored.

> *I'm just glad I got the chance to make it up to them.* (Fieldwork contact)

Some women have had new babies, believing that giving birth and becoming a mother represented their second chance in life. Many, as noted above, talked about their babies and children transforming their lives and as epiphanies. Women consistently mentioned how they overcompensate with younger children because of guilt feelings around their non-availability to an older child or because a child was placed with someone else. One focus group participant said

> *It's like I'm starting all over again, do you know what I mean? … But I find now that I feel guilty for that so I try and put a lot more into my youngest daughter, do you know what I mean, because I feel like I'm overcompensating for me eldest daughter, you know what I mean, like because today she's still living with me mother. She doesn't know what it's over. Like she doesn't know why she stays with her granny during the week and why she only comes out to me at the weekends.*

While all of the women whose children were in the care of others worked hard to defend their suitability or potential suitability in the future as mothers, some succeeded in a variety of different ways. Sometimes becoming drug free or stabilised on methadone was the deciding factor, other times leaving a violent relationship, getting a place to live, or starting out on a new career opportunity has led to this occurrence. On other occasions, the women's children have decided that they want to be with their mothers.

Some women who had lost children to the care of others believed that one day their children would live with them again. They did not see loss of custody, especially if it was to family members, as the 'final showdown'. They generally believed that if they *'work at it'* and become stable, drug free, rehoused or reform in some way, they could get their children back. Some believed that they will have a second chance.

Other second chance type experiences were also described. Some recalled the epiphany-like experience of birth, parenting, being challenged, losing of custody, events that often motivated them to become stable or drug free and concentrate on their parenting role. Rebuilding relationships with children from whom they have been separated was a stated key priority for women on leaving prison, treatment and residential programmes. These women's experiences of reunification, although few and it appears rare, are interesting as in other jurisdictions these experiences rarely occur (Akin & Gregoire, 1997; Knight & Wallace, 2003; Kovalesky, 1997, 2001; Kovalesky & Flagler, 1997; Smith, 2003; Smith, 2002; Testa, 1997; Wellisch *et al.*, 1993) and consequently the reunification process and its challenges are rarely studied (Carlson *et al.*, 2006; Smith, 2002; Sterk *et al.*, 2000; Sun, 2000).

Preserving Motherhood – the women's custody arrangements

In Chapter Four, the trajectory of drug-involved motherhood was identified as having emerged from the data generated during the fieldwork. The overarching process or narrative identified in this study was that of preserving motherhood, the task that must be accomplished by the woman drug user in the face of disapproval, assumptions and stereotypical representations. Some of the Dublin women's experiences resonated with the experiences of other women drug users elsewhere in many of the studies reviewed earlier.

The women's parental involvement and children's living arrangements present a clear picture of the diversity of experiences over time and their successes or failures at preserving motherhood. During fieldwork many women described their experiences of interruption to the role of mother. Some women, in total 15 (57.69%) of the 26 women interviewees, 28 (63.63%) of the 44 focus group participants and a loosely estimated 75 (60.97%) of the 123 mothers encountered during observation, experienced loss of custody. Some had lost all contact with their children. Three women interviewees and several focus group members and street contacts retrieved the role, while several others partially recovered their role.

The women interviewed were involved either in full-time, part-time, or occasional parenting, all having contact with some or all of their children, notwithstanding living arrangements. The 26 women interviewees, two of whom cared for four children of other women drug users, were the birth mothers of 64 children. Nine children had reached adulthood, six of whom were parents themselves, and their living arrangements had varied over their lifetime. Of the 59 minor children, including the four foster children, 27 lived with their mothers and in some cases their fathers, while 32 resided with alternative carers.

The 44 women focus group members were the birth mothers of 97 children and the foster mothers of two children. Of the 99 children, including the two foster children, 50 were currently living with their mothers and 47 were currently separated. All the children of nine women, all of whom were using drugs at the time of the research, were in the care of others.

Of the 26 interviewed, 18 women resided with some or all of their children. Seven women's parenting careers were discontinued for a variety of reasons, either temporarily or permanently, as all their children were placed in out-of-home care. One woman, her three children now independent adults, had experienced the interruption of her mothering career on several occasions and eventually it was terminated. Furthermore, five of the 18 women caring for children had one or more children living elsewhere, while two women experienced various interruptions at different stages but later retrieved the role. In total, all or some of the children of 12 women were in the care of others. While this is further evidence about the women's actual day-to-day involvement in parenting, the nature of that involvement and the challenges encountered, the difficulties experienced by the children in terms of parent-child and sibling separation are also inferred. Of the 32 minor children living apart from their birth mothers, 20 lived with other relatives and 12 children lived in foster care.

The seven non-custodial mothers had varied contacts with their children, the frequency of which often depended on the nature of the alternative care arrangements. All of the children of three women were in the care of family members, while all the minor children of a further three women were fostered by non-kinship carers. One woman's three children were in a combination of care arrangements, two of her three children living with non-kinship carers, while her third child lived with her father, paternal grandmother and aunt. One woman's sister was caring for all her children since she became homeless. Another woman's mother was caring for her only child, while the five children of another woman lived with various relatives. Invariably the children separated from their mothers were also separated from several or all of their siblings.

Five women had several children currently in the care of their family members, while they continued to parent other children. Three women had in the past lost all their children, although two later retrieved them. Seven women, having lost all their children to the care of others for varying reasons, were currently experiencing interrupted motherhood.

In the course of the study, 15 of the 26 women interviewed related how they had lost the mothering role of some or all of their children and have had differing degrees of involvement at different stages of their drug-using careers. For the 11 women who have parented their children consistently throughout their lives regardless of their involvement in drug use and maintained that role to date, it is interesting to note their circumstances. Three women resided with their families of origin, their children were all under three years, while two other women's children were under one year. Long careers in mothering alongside drug use, drug treatment or dealing with the aftermath of having been a user stretch out ahead of them. While it may appear somewhat pessimistic to suggest such exigency, on the basis of the accounts of workers and their older peers, it is possible and probably realistic to hypothesise that several women may encounter some challenges in the future. Four women have had partners who were very involved in parenting and who assisted them greatly

while they were using drugs. Two women currently using drugs had children in their care, one of whom had already placed one of her three children in her sister's care. The other woman was just starting her motherhood career and caring for her young baby. These women have successfully managed to preserve their parenting role. Indeed, as already seen, some have experienced challenges but have successfully defended their mothering role to date. Younger women reported very positive recent experiences of pregnancy, birth and the aftermath, while older women's accounts of experiences were generally more negative. Those least likely to have the care of all of their children were those who had larger families, spent lengthy periods in prison or residential treatment programmes and whose health was affected.

In summary, 27 (39.70%) of the 68 children always resided with their mothers. Of the 64 children born to the 26 women, 37 (57.81%) experienced separations, sometimes on a number of occasions, from their mothers. If the four children fostered by two women are included, then 41 (60.29%) of 68 children have experienced separations from their mothers during their lifetimes. Forty-four children (68.75%) were affected by separations from their siblings and again where the experiences of the foster children are considered, 46 (67.64%) children have experienced separations from siblings. Of the 97 children born to women who participated in focus groups, 47 children (48.45%) were currently separated from their mothers. Thus, there were several care and residence trajectories for children suggested by these data. Several children resided with both parents, while other children resided with their mothers. Some resided with alternative kinship carers, such as grandmothers or other family members and several children lived with foster parents. Some children had lived in a range of these situations during their sometimes very short lifetimes and interruptions to these arrangements reportedly were common. They were impacted upon by parents' participation in residential drug treatment programmes, imprisonment, hospitalisation, separation and, in some cases, death. Living arrangements with family members and foster carers often were often prone to change, disruption and uncertainty.

Additionally four groups of women with varying experiences of drug-involved motherhood were identified. There were those who had successfully (to date) preserved their role, status and identity as mothers. This was manifest and measurable by their involvement, either full-time or part-time in the mothering of all or some of their children. There were also those who, while preserving their identity and status as mothers, had lost the role. Keeping their 'mother' identity and status was, it appears, easier for those women who gave up the mothering role as a result of illness or homelessness. Several women, who while preserving their identity, had lost status in the eyes of others and lost their role, as evidenced by several whose children were placed in the care of others or *'taken'* into care. Several women had lost the role, status and identity of motherhood. This group consisted of a small number of women, including several who had spent long periods in prison, were immersed in chaotic drug use, homelessness, suffered mental health difficulties and had little or no access to and contact with their children.

Conclusion

This chapter examined the participants' experiences of loss of their motherhood role and custody of their children. Every woman met in the course of fieldwork described varying challenges to the mothering role by their mothers or other family members in some cases, by their partners or former partners in others, or by social workers in several cases.

The consensus among the women was that challenges were often mounted for a variety of reasons, including concerns about child protection, but often succeeded because of the stigma and perceptions associated with drug use. Family members were often the challengers. Inundation in drug use, the lifestyle, imprisonment, and the onset of illness, physical and mental health difficulties presented challenges to some women. Loss of accommodation resulting in homelessness and hostel or B&B accommodation impacted significantly on several women's ability to maintain their motherhood role. Using a range of strategies some succeeded in defending themselves against these challenges, resisting attempts by others to remove their children from their care.

Of the 26 women interviewed, 15 however described the temporary or permanent loss of their motherhood role and separation from their some or all of their children. Those who lost their motherhood role retained the identity of motherhood – 'being a mother'. The women were no longer 'doing motherhood' in the full-time or even part-time sense of caring for their children. Reunification with these children rarely occurred, even where the women entered drug treatment, became drug free or were rehoused.

Their subsequent contact with their children and their relationship with them depended on formal or informal access arrangements and the goodwill of family members, foster parents and social workers. Many women were concerned about the effects of their visits on their children and these visits often proved to be emotionally challenging for the women also. However there was a reported reluctance to permit regular and free access to children. Lack of social work staff, resources, transport difficulties, parents' inappropriate behaviours with their children were offered as reasons for decreased access. Many of the children had to endure separation not only from their parents and other kin but also they were often separated from some or all their siblings and placed in a variety of living situations. Others, a very small number of women met in the course of fieldwork, were deprived of ongoing or any contact with their children.

Notably several women identified their acquiescence in placing children in care as evidence that they were good mothers, putting their children's needs first. If women however defended their role, resisting their children's placement with others, they were regarded as non-compliant or aggressive and care proceedings often commenced or were threatened.

Following custody loss, identified as the most major painful life event experienced, the women often *'gave up'* on a child in the care of others, instead focusing all their attention and care on the

child or children then remaining in their care. However almost all harboured a belief that they will eventually be reunited with their children. They also believed that becoming drug free or stable was impossible as they dealt with the loss of their children and their continued futile attempts at recovering their role.

While several recovered their role securing a second chance at being mothers and doing motherhood, the vast majority did not have their role restored and remained non-custodial mothers. Effectively, there was a sense of finality about custody loss, even where it was suggested as a temporary measure. They failed to retrieve their motherhood role and access, child visiting and contact also reportedly diminished or ceased over time. While many women interviewed lived with at least one child, an appreciably high number was neither residing with nor caring for any of their children.

The next chapter will explore how the women participants and professional workers interviewed describe the women's views of good mothering, the impact of their drug use on their children, how they aspire to be the Good Mother and idealise the motherhood role.

CHAPTER EIGHT

MOTHERHOOD IDEALISED:

ASPIRING TO BE 'THE GOOD MOTHER'

> In practice, idealized bonds of motherhood may be neither realized nor realizable, but the evocative image of motherhood can continue to provide a culturally powerful metaphor with which to think about social life. (McMahon, 1995: vi)

This study has explored how the women participants experienced their motherhood role and defended it against challenges from a range of key actors and during key crisis moments. Chapter Seven examined the experience of those who lost their children to the care of others and the few who later successfully retrieved or recovered their role. This chapter further explores the women's defence of their motherhood role epitomised by attempts to achieve 'fit mother' status, the centrality of this endeavour in their lives and how in attempting to put their children first, even where both careers collided, they aspire to be good mothers.

All women, as mothers, apparently strive to attain idealised, socially constructed or 'invented' standards of motherhood, unrealisable and unattainable (Badinter, 1981; Boyd, 1999; Dally, 1982; Gillies, 2006; Kitzinger, 1978; McMahon, 1995; Oakley, 1974, 1979a, 1980; Rich, 1986). Underlying motherhood as a social construct, then, are notions of selflessness, giving and prioritising children's needs, a vocational commitment deemed as 'labours of love' (Ettorre, 1992; Finch & Groves, 1983; Lynch & McLaughlin, 1995; Rich, 1979). However, concerns about good mothering and attempts to attain such standards by women who use or have used illicit drugs are doubly problematic (Baker & Carson, 1999; Boyd, 1999; Brown, 2006; Colten, 1982; Enos, 2001; Ettorre, 1992; Friedman & Alicea, 2001; Goode, 1999; Murphy, 1992; Rosenbaum, 1979, 1981a; Sterk, 1999a; Taylor, 1993). The ideology of motherhood pertaining in Irish society, strongly undergirded by images of motherhood in Catholicism, is not unlike the ideology of motherhood universally (Inglis, 1998; O'Connor, 1998). More modern, secular, expert-driven definitions of appropriate parenting draw on similar characteristics (Gillies, 2006; Kennedy, 2004; McMahon, 1995; Peterson *et al.*, 1996; Scourfield, 2003).

In the light of this literature, the women's and workers' views of good motherhood and the incompatibility or otherwise of drug use and motherhood are explored. Firstly, the participants' views are recounted, highlighting the conflicts between simultaneous drug use and motherhood. Secondly, the women's perceptions and definitions of good mothers are described. Then their understanding of the impact of their drug use on their children's lives is examined. Finally, the impact of the ideology of motherhood, its perceived incompatibility with drug use and difficulties with colliding discourses about this issue are discussed.

Drug use and Motherhood – Mutually Exclusive?

Drug use and parenting are not mutually exclusive activities ... [Social Worker, W 26]

In reality, drug use and motherhood are not mutually exclusive activities. Successful management of drug use and motherhood was described earlier, as was involvement in drug treatment and motherhood. However, motherhood experiences while using drugs and views about the combining of the two careers varied.

To reiterate, while this study explores women drug users' experiences of motherhood it is not concerned about establishing whether women drug users are in actuality good or bad mothers. As highlighted above, standards of good, bad or appropriate mothering are socially constructed, defined and dictated. Even standards of appropriate parenting or good enough parenting as recently defined by social work academics and practitioners are determined by the context and indeed the occupational cultures and ethos in which they are developed (Buckley, 1998a, 2003; Scourfield, 2001, 2003; Skehill, 1999). This study is not concerned with the impacts on children of being parented by a drug-using mother. However, it explores how women drug users perceive motherhood, understand notions of 'good', 'bad' and 'good enough' mothering, and also how they perceive the effects, if any, of their drug use on their children. It is also interested in interrogating how women drug users are perceived by others. Stereotypical representations about drug-using mothers abound as highlighted earlier (Campion, 1995; Friedman & Alicea, 2001; Klee, 1996, 1998; Rosenbaum, 1981a; Taylor, 1993). So far this thesis has argued that beliefs about women drug users as bad parents at moments colour and impact upon their experience, often resulting in the standards expected as far higher than those expected from other mothers.

Workers' views

While most worker participants agreed that drug use and mothering were mutually exclusive activities for some women, few stated that drug use and motherhood were impossible to combine. Several argued compellingly that drug use and motherhood were not mutually exclusive activities, while the majority qualified their responses considerably. Although almost all were generally positive about women drug users and their involvement with children, when asked specific questions about competency while using drugs they became visibly uneasy and expressed ambivalent attitudes. Many experienced some dilemmas in responding to families and did not wish to be seen as apologists for poor childcare and child rearing practices. Others clearly stated that *'stable'* drug users in treatment are the *'best people to be with their children'* [Community Worker, W 05].

Although few admitted it, one social worker [W09] acknowledged that a belief that drug use and parenting can occur simultaneously was not a popular view to hold in her profession, echoing Adam's (1999) findings that social workers generally believed that parents living with children should not use drugs.

I think they can happen together. Yeah I do. It's not a very, a particularly popular view but yeah, I do believe they can co-exist. But I think it depends on how it's managed and how sensible you are about it and again it depends upon the parent too.

Another social worker [W 13] highlighted how often workers were *'blinded'* by the drug use and automatically assumed that there were child protection concerns.

In the 1980s I found that a lot of my cases were drug-related and drug-using parents who were in treatment when the abstinence model was the order of the day. There was a view that they ought to let go of their children, that they needed to be in care. You'd get bombarded with nebulous complaints and it was difficult trying to elicit concrete information. The children were being used as therapeutic pawns to motivate the individuals into terror ... Has that changed?

This issue of assumptions about drug-using parents emerged throughout. The conflict arising as a result of the workers' knowledge about the potential impact of drug use and associated lifestyle on the parental capacity and the health and welfare of children, and the tendency to assume that these impacts in reality existed in every case were evident in many accounts. Assumptions that any difficulty emerging for drug-using mothers arises as a result of the mothers' involvement in illicit drug use *per se* pervade the literature about pregnancy and motherhood. This belief may seriously conceal other crucial issues requiring responses with serious repercussions for women's and children's health and for the services responding (Hepburn, 1996).

Almost all workers maintained that drug use *per se* is not a reason to take children into care. Nevertheless, several offered conflicting views and statements at different points during interview. One social worker [W 32], who described drug-using mothers as *'disasters, all of them'* at one point, stated later that,

Drug use per se is not a reason to take children into care.

Another social worker [W 37] identified the conflicts inherent in what workers say they believe and what they do in practice.

A lot of people would probably say, you know, if you're to be politically correct, "well just because you abuse drugs doesn't mean you abuse your children". But in fact to be honest about it, if you're abusing drugs over a long period of time and the health board are involved, it's very rare that you are minding your children properly in reality. You can't if you're on drugs.

Being *'politically correct'* and offering the common refrain of *'drug abuse does not equal child abuse but ...'*, mentioned candidly by this worker, echoed other research findings that suggested that social worker respondents' answers in questionnaires were often modified significantly when faced by a colleague as interviewer in follow-up qualitative interviews (Adams, 1999). This 'drug abuse equates with child abuse' or 'abusers twice over' belief is apparently common (Colten 1982; Friedman & Alicea, 2001; Norman-Bruce & Kearney, 1990; Perry, 1979, 1986; Smarsh Hogan *et al.,* 2006; Taylor, 1993). Findings about treatment optimism among social workers elsewhere also are mirrored in this study (Adams, 1999; Akin & Gregoire, 1997; Forrester & Harwin, 2004, 2006).

These pessimistic views about the outcomes for drug-using mothers were not confined to social workers. Several drug treatment professionals expressed similar views. One community drug worker [W 38] described the issue as both disturbing and distressing.

> *I find that there is no parenting skills in the sense that the people who come in are struggling either with their habit or poverty and what comes with that and then they also have a child. Now they love the child ...and the child loves them. But sometimes it's very abusive in here what happens to children like you've the shoutin', the slappin' and that's what I see and I don't give a shite what anybody says or if anybody denies it, that's what I see. I'm not saying all parents, I'm saying some parents.*

Generally, drugs workers and addiction counsellors, while they believed that the majority of their clients were adequate parents, were sometimes less confident in their assertions than those with medical or social work qualifications. Many drug workers, counsellors, doctors and nurses working within the drug field perceived other professionals, such as social workers, public health nurses, doctors and others, as disapproving of women drug users' involvement in parenting. Some workers, in the drug treatment and social work fields, claimed that other workers espoused negative views.

> *In my experience the workers in this field have a very negative attitude towards the parenting - to drug users being good parents.* [Addiction Counsellor, W 21]

> *I think they vary and not unlike the general population, there's some of them are extremely good parents and I think that needs to be said to dispel the myth that most social workers, PHNs, doctors believe. I've met psychiatrists who've asked me regularly "But she's pregnant, what will we do?" And almost you can almost see the care order in the man's head as he's speaking to you.* [Nurse/Outreach Worker, W 10]

Several respondents emphasised that the illicit nature of the drug use and the lifestyle associated with it were the reasons for a lot of the difficulties. They viewed the parenting work as satisfactory, *'good enough'* and competent in many situations, even if it was challenged by poverty and lack of resources, as the parenting of many non-drug-using women is also affected (Banwell & Bammer, 2006; Smarsh Hogan *et al.*, 2006).

> *I would have seen women who were off drugs who to me wouldn't be capable of minding their children and I would have seen women who were on drugs who would be capable.* [Social Worker, W 37]

> *I'm not saying it doesn't have an effect on children but I think there are a lot of other factors, ... are a lot of other situations and other parents maybe whose parenting capacity isn't as much under the microscope.* [Social Worker, W 01]

> *There's a perception because you're a drug user you're a bad parent, I suppose that's the major one and that a lot of the supports maybe that people could have accessed were prejudiced by that initial notion. ... There are drug users that are bad parents ... it's not necessarily because they are drug users.* [Nurse, W 07]

Others suggested that the lifestyle associated with drug use is the main problem affecting availability, supervision and protection.

> *But I think people who use drugs chronically over years and years, and if they're having to go out and rob, it's not the drug use per se that causes them not to mind their kids. It's what they have to do, the lifestyle associated... They can't*

mind their kids properly, it's not possible because there's neglect, emotional neglect at the very minimum. [Social Worker, W 37]

Recognising the seriousness and importance which the women attributed their motherhood role, status and identity, their having and being with their children, they argued for a family support focus and treatment programmes that address family and child care issues, also recommended in a range of other studies, reviewed earlier.

In the workers' views, many women regarded their responsibilities as important and understood the impact of the drug use on their children. They suggested that the women always tried, albeit sometimes unsuccessfully, to minimise the effects and impact of their use on their children, describing similar practices as described in Chapter Five and as viewed in the literature review. They also discussed the impacts of a range of structural issues, as noted in Chapter Six, suggesting that issues other than drug use, such as environmental risk factors, poverty, deprivation, negative childhood experiences, violence, homelessness, mental health challenges, imprisonment and social exclusion generally, impact on parenting despite common perceptions that it is a simple situation of drug use and bad parenting going hand in hand. The workers' broad social analysis echoes other research findings in Ireland and elsewhere with regard to the plethora of risk factors.

Several workers spoke at length, some pessimistically, about the inevitability of transgenerational concerns with regard to parenting, suggesting that observations and experiences during childhood years impacted upon parenting skills. Throughout they challenged the notion of a natural and inevitable ability to parent *'in and of itself'*.

I think it's something that you can either learn or you have a memory of yourself, of how you've done it or how you've been, or how your mother was, or how your father was that that will give you some kind of instincts or knowledge somewhere in yourself of parenting ... you might replicate or do something similar to maybe what happened to you. [Addiction Counsellor, W 19]

Workers expressed suspicions that sometimes children met their mothers' needs rather than *vice versa*. Some focused on the children's experiences, the women's love for their children but they also mentioned *'inappropriate'* parenting practices, some describing these as *'so emotionally abusive'* whereby children were treated as adults and with no clear boundaries or limits. The number of alternative carers involved in caring for children as a result of hospitalisation, imprisonment, movements, different placements, inconsistency or separation and loss were also a concern, also identified elsewhere (Enos, 2001; Hogan, 1997, 1998; Hogan & Higgins, 2001a; Kroll & Taylor, 2003; Lewis, 2004; Schilling *et al.,* 2004, Smith *et al.,* 2004).

Separation and loss . . .are specific to drug-using parents because of things like imprisonment or ill health as a result of drug use . . . So I think that those needs need to be looked at in terms of supports for the children. [Social Worker, W 26]

Five professional workers suggested that women sometimes regarded their children as burdens or fetters, one social worker [W 32] suggesting that children get in the way *'because drugs are their God'.*

Conversely, others discussed the women's viewing of their children as redemption, an issue that will be further explored below. One medical practitioner [W 30] suggested that many women experienced varying levels and quality of parenting themselves. In his view, *'broken as people'* they viewed pregnancy and birth as *'a restitution ...the only good thing in their lives. "I can have a baby". It's an inherent reaction'.*

> *It's almost like "I'm a bad person, I'm an addict" but it's almost the only good thing in their lives ...it's almost like "I'm going to make up to this baby and I'm going to try and ensure that they don't have the life I've had ...*

Workers also discussed perceptions of drug-using women as mothers and the almost *'blanket acceptance'* of them as *'failed'*, *'unfit'*, *'incapable'*, *'unsuitable'*, *'irresponsible'* and *'immature',* even before they begin their motherhood careers. Many suggested that viewing the women as victims was a way of counteracting or minimising the impact of their involvement in such *'unladylike'* activities.

> *What explanations do you come up with that women are using heroin? ... Women! Mothers are injecting heroin into their veins! I think like just to deal with the image of it in people's minds itself, she has to be a victim.* [Addiction Counsellor, W 21]

Consequently, in the face of such perceptions it is suggested that many drug-using women may withhold information about the extent of their drug use during pregnancy or while mothering, resisting involvement with social workers and drug treatment professionals in an effort to *'keep mum'* and preserve their motherhood role.

> *You see it's very difficult to make an assessment when you don't have the information. ... But you would have seen evidence that they were coping even though you believed that they were using a lot less than they actually were or you trusted in what they told you even though they were lying to you.* [Social Worker, W 09]

In the literature reviewed in Chapter Two and the findings presented in Chapter Six, the negative attitudes and automatic assumptions prevalent among professional workers, drug treatment providers, social workers and health professionals generally were discussed. Indeed, some social service providers were identified as equating drug use of the illicit kind with poor parenting or mothering capacity. They assumed that drug use and parenting, or rather mothering, are incompatible or mutually exclusive activities and that drug use by parents places children at risk at birth or later in life (Adams, 1999; Billingham, 1999; Boyd, 1999; Buchanan & Corby, 2005; Campion, 1995; Humphries *et al.*, 1992; Kearney, 1994; Maher, 1992; Taylor, 1993; Skehill, 1999; Smarsh Hogan *et al.*, 2006). Health professionals and social workers have been variously described as holding negative views about drug-using mothers viewing them as selfish and uncaring, irresponsible and immature, distracted and lacking interest in their children, neglectful,

intolerant, irritable and aggressive, and putting drugs and their partners first (Campion, 1995; Klee, 1998; Scourfield, 2003). These suggestions confirmed the claims of others who have examined women drug users' experiences as mothers (Boyd, 1999; Colten, 1982; Ettorre, 1992; Taylor, 1993).

Women's views

While the women described varying levels of immersion and inundation in a drug career, many managed to control their involvement with this life, particularly where they became pregnant and made the transition to motherhood. There were differing experiences of inundation however, as seen in the typologies of users offered by ethnographers (Faupel, 1991; Rosenbaum, 1981a; Sterk, 1999a) and commentators on parenting involvement (Campion, 1995). However, the extent of time inundation varied considerably from woman to woman which may account for the varied parenting fortunes of some.

There were vast differences between the women's views on drug-taking. However, all believed it was important to use drugs in as controlled ways as possible in order to *'keep everything going on track'* or to *'keep all them balls up there in the air'*, witnessed earlier.

> *If we hadn't Harry we wouldn't care a damn. But he's the most important thing in our lives.* [Brenda]

> *Where does choice come into it? I still smoke hash. I still like a drink, I still use coke the odd time. But there's the risk of the "unfit mother" thing. A lot of women are hiding that because we just feel we can't own up to it because of the way society would see us you know...There is a tendency to play down.* [Liz]

Minimising or hiding drug use and involvement in 'deviant' activities was imperative in order to keep children in their care, as has been witnessed in studies of women involved in crime and alcohol treatment (Heidensohn, 1996; Thom, 1986, 1987). However, in this study many women accepted responsibility for their actions while insightfully discussing the importance of minimising their involvement as a strategy that they viewed as a necessary component of preserving their motherhood role. This was also evident in the accounts and some of the differences and divergences in views of the women and workers hinge on this very issue.

As mentioned earlier, a small number of professionals suggested that children were *'burdensome'* preventing the women from being more involved and immersed in drug use, a phenomenon also reported in the literature (Bourgois & Dunlap, 1993; Sommers *et al.,* 2000). However this was not a widely shared view among the women or the workers. Some, a very small number of women however, suggested that their children impacted or might impact on their ability to use drugs and maintain the life. From the perspective of a drug free woman, Katherine stated that she had never used heroin and parented simultaneously, but if she had she would not have been able to do it.

> *Ah I never had kids on heroin. But I never could have. I couldn't have. I'd have killed me kids, I have to tell you the truth!*

Only one woman, Andrea, now drug-free and the full-time mother of her children, described how her children *'became a burden to me'* in reflecting how she left her children with her mother for a six month period. Another said *'I didn't have the freedom that I'd had before'* [Ellen]. Several described the difficulties they experienced, as both primary carer and drugs provider while using drugs, or the stress and challenge of supporting and caring for her partner's two children alongside her own. But in general the notion or representation of children as burdens or fetters was not a widespread one.

Instead, pregnancy, birth and motherhood were referred to throughout as offering an opportunity for redemption, as the *'best thing I've ever done'*, and children were described as the most precious things in their mothers' lives. These transforming and reforming effects have been highlighted earlier (Baker & Carson, 1999; McMahon, 1995). The women's accounts of the impact of their babies' births illustrated these views. Most women viewed their pregnancies, birth and parenting experiences as an epiphany.

> *As soon as they would be having a child they'd automatically become a more responsible person ... And like they try the best they could like not to lead the life that they led before, whether it'd be to get themselves onto a methadone programme, try and stabilise themselves and try and stabilise their lives or just knock it on the head altogether and just go through their sickness because of the love they have for the child.* [Alison]

> *When my son was born I got onto the clinic an' then I really got me act together. I says "now this is it, you have to get yourself sorted out. You have a child! Get your act together!"* [Darina]

> *I wouldn't let her* (mother) *take me child because I knew he'd make me more alert about what I was doing because of drugs. ... When I had him I knew this was it. I had to stop what I was doing cause it wasn't fair.* [Emma]

Some also identified their loss of pregnancy as a *'road to Damascus like'* experience. Having described her miscarriage as a *'horrific experience emotionally'*, one woman claimed that she *'needed that experience'*.

> *It probably sounds weird but I needed it. ... I remember going to the grave, the angels' plot in Glasnevin and saying to God, crying "Why? Even if there'd have been something wrong with her, I'd've been, I'd've looked after her". But I wasn't ready. I couldn't fuckin' function. I couldn't look after me... But I needed that experience to be where I am at today.* [Katherine]

Losing children to the care of others often precipitated these epiphanies leading to major lifestyle changes in order to retrieve children and the motherhood role. Almost all talked of birth, parenting involvement or the shock of being challenged in their parenting role as a moment of *'waking up'* - *'snapping out of it'*, *'it just opened my eyes'* and *'getting a grip of myself'*. While some succeeded in making changes as a result, others did not succeed in making the required changes. However, they spoke of birth experiences giving them *'strength'*, bringing *'light'* into their lives, and about children *'as my flesh and blood'*, the *'love of my life'*, *'I love her, I love her to bits'*. Many women believed that their children were their *'saviours'*, that they would be dead, using drugs or in a lot of trouble if they did not have their children.

Me kids keep me going. They're the hardest thing for me but you know in terms of giving meself a hard time. But they're the best thing for me cause they keep me going the days.... I'd love to stay in bleedin' bed some days and bleedin' just be depressed. But I get up and I get on with it, do you know what I mean. [Darina]

The women were painfully aware of others' perceptions of them as mothers. Consequently, they anticipated, feared and dreaded challenges to their motherhood role, often deep down believing that they were not good enough mothers, as seen elsewhere (Colten, 1982; Friedman & Alicea, 2001) and therefore vulnerable to such challenges from partners, ex-partners, their mothers, and professional workers.

I'm not an unfit mother. I treat my children better than any other bleedin' person I know. But it's a fear. Me kids, me kids, me kids .....that I'd be found out, do you know? I don't know what the hell they're goin' to find out. It's always that attitude that I'm doin' something wrong or I don't belong or whatever. [Katherine]

They themselves lacked confidence, even in situations where they have not used drugs and have been totally drug free for more than five years, confirming that a life in motherhood beyond drug use is still a challenge for drug-using women (Carten, 1996; Rosenbaum, 1981a; Rosenbaum & Murphy, 1987). However, most women without hesitation declared that drug use and motherhood were not mutually exclusive activities and discussed how they themselves combined those roles.

I think any drug-using woman is capable of looking after her children. Just because you use drugs doesn't mean you can't do that. [Liz]

Other women were more ambivalent about the combination of careers. Having lost child custody, some believed that this was evidence of bad motherhood. Feelings of guilt, shame and loss predominated for several non-custodial mothers. Twelve fieldwork contacts, three of whom were pregnant and most of whom anticipated having children in the future, described themselves as future mothers.

I've no babies yet. But I'll have them, I will. [Fieldwork contact]

Several, however, believed that the two roles were incompatible and resolved to delay motherhood until their drug–using career was finished, believing that having children and using drugs meant being *'doomed'* in the long-term.

It'd only be a short time like till everything fell down if you were doin' that. [Fieldwork contact]

One woman stood out from all the women respondents and the vast majority of professional worker participants in her vehemence about the incompatibility of drug use and motherhood. A mother *'in recovery'*, she argued that even entering drug treatment was not a redeeming feature.

Well if they're usin' anyway, the kids, I think the kids more than the fuckin' parents need the help. Now I've a huge issue, to tell you the truth, around people on methadone with kids. While some I have seen are very good parents, some aren't. But that probably goes whether you're on drugs or not... Some individuals do give their kids good care on methadone. ... Drugs fuckin' numb you. How can you be emotionally available to your kids if you're taking

> *such a level of methadone? .... But whether they're drug users or not this can happen too. ...* [Katherine]

The potential impact of these views and beliefs on experiences of drug use/treatment and motherhood was identified in Chapters Five and Six. Among 40 workers and 26 women interviewed, there was considerable uncertainty as to whether drug use and motherhood are mutually exclusive activities. Most workers, as mentioned earlier, were more at ease if their clients were drug free or maintained on methadone. Almost all the 205 women encountered during fieldwork expressed the same views, even those not yet mothers. Six accounts - one woman, herself drug free, two drug workers and three social workers - differed somewhat in their initial certainty about the incompatibility of the two careers. There is nonetheless clear evidence that the collision of two identities and roles, that of drug user and mother, may cause major difficulties and challenges for women, their children, their families and those practitioners who engage with them.

Good Mothers? – *'I'm a strong mother...'*

> *But you just, I don't know, from the time you have them it's just, whatever pain you went through just went out the window the minute that child came into the world and they are the love of your life then and you do your utmost for them.* [Sharon]

Apparently being a good mother remains the concern of most women, drug-using or non-drug-using (Baker & Carson, 1999; Boyd, 1999; Brown, 2006; Colten, 1982; Coyer, 2003; Ettorre, 1992; Friedman & Alicea, 2000; Goode, 1999; Murphy, 1992; Rosenbaum, 1979, 1981a; Sterk, 1999a; Taylor, 1993, 1998). In this study, the women's definitions of good mothering included a focus on both instrumental and affective processes, their performances guided by a number of underlying principles. One such principle is that of meeting children's needs and putting children's needs first. An emphasis on *'keeping the fridge stocked'*, *'putting food on the table'* and *'putting a roof over their heads'*, meeting basic instrumental needs with regard to food, housing and clothing was evident in many accounts. Their families' and community's expectations with regard to physical and material needs were central to definitions of good motherhood. Some argued that they always put their children's needs first, while others acknowledged that drugs needs sometimes came first.

Another guiding principle is *'doing it differently'* to their own parents' performance in terms of physical availability or presence, emotional availability and providing a good, rather than absent or disinterested, father. Protecting their children was also central. Further, the principle of atonement, that is to make up for being *'bad'* women or mothers by virtue of being drug users simultaneously or having been users in the past, is also noted in other studies (Kearney *et al.*, 1994; Sterk, 1999a). In this context, the women reported guilt, shame, overcompensation and over-protectiveness. Simultaneously meeting emotional, educational and developmental needs were mentioned throughout and appeared to be similar to the professional workers' expectations with regard to affective, developmental and communication needs.

It appeared that the women's mothering standards and their understanding of what a good, good enough or fit mother does or should do was constructed as a result of interactions between themselves and others, parents, partners, and professional workers, as viewed in previous chapters. They were constructed, learned, dictated and supervised through, what Murphy (1992: 151) in her study of crack-using mothers, has described as the 'ideological supervisor' which is

> the mechanism by which mothers evaluated their own and others' mothering work ... an inner voice which constantly evaluated child rearing practices and outcomes. Other observers (e.g. fathers, grandparents, teachers, social workers) also brought their own "ideological supervisors' to the interaction, judging women by criteria based on their own gender, race and class memberships (pp. 152-153).

Women's experiences of being mothered as children, the views and mothering standards of other mothers and those around them and the representations of mothers, mothering and motherhood are key components of this mechanism.

Identifying their central role, principally the women defined themselves as mothers. Whether full-time, part-time or non-custodial mothers, their identity of mother outweighed that of drug user. The majority, while sometimes critical of their performance, recognised themselves as *'good enough mothers' or 'fit mothers'*, performing the physical and emotional tasks of parenting. However, concurrently many believed that they were not *'proper mothers'* or *'normal parents'* because of their drug use.

> *Ah you just love them so much it doesn't bother you. You just do what you have to do, feed them, change them, bathe them and whatever they need you give it to them you know. Once, well once you're taking care of the children properly and feeding them and making sure they have a roof over their heads. I was a good mother bar through addiction.* [Sharon]

All aspired to be *'good mothers'*. In interviews and focus groups, animated conversation about the motherhood role took place.

> *Well to me it's being there for your children, being able to take care of your children, being able to dress them, have their dinner and if they fall and hurt theirselves, they can call you and you're there for them. 'Cause when I was growin' up me mother did all them things for me, do you know what I mean?* [Emma]

> *I'm always puttin' myself down but I do think I'm a good mother. Like I put my kids first, and they always have their wants and their needs, I have their uniforms for them goin' back to school, I've their school books ready for them, like I have what they, you know. ... Once you love your kids and show them a bit of love and affection and I mean you feed them and look after them, that's a good mother. I'd love to be out of the area and I think education is very important, very vital.* [Darina]

They emphasised the importance of love, affection, warmth, and showing concern and care in ways that involved giving children time and attention. They also mentioned the necessity of praising and affirming children, arguing that a child should never be deliberately undermined, criticised or put down.

> *A good parent just listens to their children, loves them and then to be there for them all the time, even like if you're in the middle of something ... And affection and love, like you have to give them all that.* [Marina]

> *Listening to your kids and telling them that you care about them is important and you want them to be happy and whatever they decide to do in the future is OK.* [Ellen]

Good mothers also protect children from harm. Several women, as discussed earlier, left their children in the care of others to ensure their protection. It appeared that those most concerned with protection were those who had experienced abuse as children.

> *It'd kill me stone dead if anyone touched her. Oh, I can't even bear thinkin' about it. I'd do life for them. It happens too much ... Most women drug users got abused by someone somewhere.* [Marina]

> *I'm terrified that my kids will end up fucked up the way I did, that they'll experience like abuse and stuff like that, like I did. I'm over-protective and as a result, I put a huge strain on myself to do it right. Now I know there is no such thing as a perfect mother.* [Katherine]

Some stopped using drugs or changed the context in which they used to protect their children.

> *It just kind of changed me a bit ... and I was this protective mother and the smoking of the dope with gangs was still going on and I had a responsibility to a child and that had changed for me.* [Ellen]

All agreed with Rachel that encouragement in education and schooling is crucial so that their children have *'a life better than me and their father had'*.

> *The life I had...I wouldn't like them to go through what I went through! I wouldn't like them to have to go out and rob knowin' how well they speak, how well they are.* [Arlene]

Several women used the term *'twenty four seven'* to describe the responsibility, the duration of this care and attention. Others talked about meeting their children's basic needs for food, clothing and shelter, while many talked about their children's need for stimulation, play, fun, education and movement. They considered parent/child interaction to be crucial and hoped that their children were well behaved at school and in the neighbourhood.

Most women, while acknowledging that there was *'no such thing as a perfect mother'*, constantly maintained that they were *'good mothers'* or at least *'good enough'*. Other women drug users, their children, partners, mothers, members of their families, communities, counsellors, drug agency workers, doctors and social workers had affirmed them as parents. Several had never been told that they were parenting well, while some were constantly criticised by mothers and partners. While some younger women demonstrated great confidence as parents and believed that they would never be challenged in their motherhood role, several older women were less confident. Lack of confidence about mothering skills emerged in several accounts and while women described how they mothered well, they also identified their limitations.

Most women asserted that they wanted to *'do it differently'*, wanting to mother their children differently to how they were mothered when children. This of course had little to do with drug use. Helen, referring to the fact that drug use and motherhood are not mutually exclusive activities, specifically said

> *Well my mother wasn't on drugs and she wasn't the best mother, you know.*

In fact 19 (73.07%) of the 26 women interviewees described their mothers' responses to them as distant or indifferent, cool if not cold, hostile in some cases and very critical of them as they were growing up. Some, even those who felt loved and cared for by their mothers, claimed that they would be less naïve in terms of limit setting, discipline, supervising involvement in education, communication skills and awareness of risks of early sexual activity, drugs and alcohol.[121]

As a result of their own experiences as children, they were intensely aware of how the pressures of keeping the home together, working, street trading, cleaning, dealing with errant and irresponsible partners impacted on their mothers' ability to be there for them. The women witnessed their mothers' performances which involved *'juggling'* a range of roles, dealing with poverty and managing households often in the absence of fathers, lack of communication with their children and the meeting of instrumental and basic needs for food, clothing and shelter. As one woman said humourously,

> *A good mother provides for her children. I'm a good shoplifter. I provide well for my children. Therefore I'm a good mother!* [Amy]

In terms of communication and emotional needs, many claimed that *'you brought yourself up'* and the others too if you were the oldest sister. Economic necessity, financial difficulties and hardship dominated their mothers' experiences of motherhood. Similarly, these financial difficulties dominated in the women's accounts of mothering at all stages of their drug-using careers and beyond.

Many believed that time, closeness, both physical and emotional, love, meeting needs, honesty, some freedom and a certain amount of discipline is necessary. However, significantly many based their definition of *'good mothering'* both on what they lacked as mothers with their children and what they lacked from their mothers as children.

> *Maybe you see my notions of what a good mother are would probably be based on what I lacked myself like. So it mightn't be really what a good mother should be at all ... To be a good mother, I mean, I think you need to be a genius, as far as I can see. You'd need to be a psychiatrist and a lot of things besides, you know. It's hard you know ....and you think "God am I doing it wrong?", you know . I don't really know what a good mother is.* [Brenda]

> *I think I was a good mother. I think there were times when I wasn't ...like when I left them ...I think my drug use, yes I think it did , it did affect them. I was a bad mother then, I feel, because when I was in withdrawals I couldn't bear them, I couldn't handle them, I couldn't look after them the way I think I should*

[121] Having said that, there were very low levels of criticism of parents.

have and the way I think they needed. I think I'm a good mother now ...I don't think it was actually me that wasn't the good mother... it was the lack of support and no access to treatment. [Liz]

They also stressed the importance of providing their children with a *'responsible father'*. Providing children with a *'good father'* was also seen as the role of a good mother. The women wanted their children to have a father, and preferably the one father.

> *I think that there are parenting issues in that they tend to be the main carers, that working class men, inner-city men don't see that as their job to have to care for the children. There's an issue around multiple fathers as well that I relate to drug use, not being clear about the relationship with the children. A lot of women have children by different fathers. I can't duck that. I have difficulty with that. I think it poses difficulties for children.* [Community Worker, W 05]

Notably, the women often provided support to others, family members, partners, parents and others in the drug-using community. While their partners were present, their drug use too had to be managed. While the women were often offered treatment because of pregnancy and childcare, their partners were somewhat problematically often excluded from treatment, creating additional problems for the women, such as tensions in relationships and upkeep of households. While in treatment or drug free, they often contended with partners' continued use and imprisonment. In some cases, they accessed their partners' drug supplies. In many cases, they negotiated treatment programmes for their partners in an effort to provide their children with a *'good father'*.

In the main, they aspired to the two-parent family, some women remaining in emotionally unfulfilling relationships because their children's needs for their father to be present and involved in parenting.

> *I had loads of fuckin' relationship difficulties....but I kept with him, I think for the kids sake and I've always said that the one parent happy home is better that the two parent unhappy home....* [Katherine]

> *He'd beaten me up that much. And when he got out of prison, he'd nowhere to go and he asked me could he stay just for the Christmas with the kids. I wanted the kids to have him at home for Christmas. And that was his way of getting back in and he got back in and that was it then.* [Laura]

Some have left relationships and left children with the father, while many suggested that their partners or ex-partners were excellent fathers. While 11 women described their current or ex-partners as *'good fathers'*, relatively supportive in parenting, this was often conditional and dependent on the state of their relationship, their drug use or whether they were in prison. However, as described in Chapter Five, the women's partners were often more present in their children's lives than their fathers had been in theirs. Perhaps drug-using unmarried fathers are often more involved with their partners as a result of the rejection or exclusion of the women from their family systems. Generally, the findings of a range of studies on lone parenthood in Ireland suggest a marginalisation of men in the family (McCashin, 1996; O'Connor, 1998: 122).

Some non-custodial mothers believed that they had made responsible decisions which indicated their *'good mother'* actions. They regarded placing their children into kinship or non-kinship care as achievement in itself and recognition of the primacy of their children's needs.

> *That's why I feel I'm a good mother because I did for my children what I did. I may not have been always a great mother but I feel that I made the right move to do what I did till I get my head straightened out.* [Sharon]

Several women made the decision to ask other family members to take on the care of their children because of living in B&B accommodation.

> *I am a good mother, I really care about my children and I did Ok, (social worker) told me so. ... I felt so bad about handing them over like that even though I know it's for the best. She'll (sister) be able to give them everything they need. She has a lovely home around them.* [Sheila]

As noted earlier, they displayed significant support, solidarity and understanding of their own, their mothers' and their contemporaries' experiences of attempting to raise their children in adverse economic circumstances. While some lost their motherhood role, sympathy for women in this situation was articulated. While women spoke of the *'good mother'*, they rarely mentioned *'bad mothers'*.

> *But they're all good mothers. We all try to be good mothers. You just try to be a good mother and that's it! We're all good mothers.* [Jenny]
>
> *I do really feel that everyone does do their best as a mother.* [Andrea]

They also strongly rejected the *'one size fits all'* approach acknowledging that while there were mothers who were unsuccessful, there were others who managed and often managed well.

> *It annoys me when people say drug users are unfit mothers. There are mothers out there who take drugs who don't care about their children. But there are lots of girls who are using heroin or on the clinic and they're great mothers. Their children are not neglected in any way at all.* [Janet]

The issue of defensiveness also emerged. If women were challenged, they often made stronger assertions about good parenting. This was echoed in workers' accounts.

> *Especially if there has been some sense of being threatened or their parenting being questioned, then I think it would come out then, you know. "Well at least I'm not doing that" or "Well I'm stable on my methadone, I haven't used in ages". So there's always ways of talking themselves into being a good parent. I think it's very difficult to actually see themselves as a not so good parent.* [Addiction Counsellor, W 36]
>
> *I think a lot of denial goes on really, not just with drug-using parents. I think the first thing a lot of parents say is " I am minding my kids well" because how they might measure that might be very different to how a social worker would measure it. I mean for a lot of parents, their own experiences of growing up have been so negative and abusive anyway, that they might measure it just because they feed their kids maybe and because they don't beat their kids.* [Social Worker, W 37]

The *'good mother/bad mother'* dichotomy was observed throughout workers' and women's accounts, many suggesting that this good/bad distinction often resulted in negative perceptions of

pregnant women and mothers. Others described how the labelling of the women as 'bad' or 'unfit' parents impacted on their parenting behaviour, resulting in overcompensation and other defensive strategies. As seen in preceding chapters, mothering in a defensive manner, self-conscious performance, overcompensation, giving children material and other goods, ensuring their children were well behaved, keeping families and partners happy or *'keeping social workers at bay'* became the focus of their existence. These reactions have been witnessed in other studies of drug-using mothers, where women have engaged in what has been described as 'defensive compensation' in order to be 'good mothers' despite their drug use (Brown, 2006; Kearney *et al.*, 1994; Murphy, 1992; Sterk 1999a: 115).

The isolation of many drug-using mothers was stressed.

> *I think those who were good mothers knew that they were good mothers and got on with it ... But if they had doubts about their ability as mothers then that would eat away and gnaw away and again their esteem issues would lower again.* [Addiction Counsellor, W 02]

Some mothers did not succeed in caring for their children as noted in Chapter Seven. They failed to defend and maintain their motherhood role. Nonetheless many felt that they performed well and appropriately in their now limited mothering role.

While several women were content to have their motherhood identity and status, even though they were non-custodial mothers, most wished to perform the mothering role and to parent on a daily basis. However, all the women believed that had to do more than just successfully perform parenting tasks. In the words of one addiction counsellor, *'it's always a case of goal posts moving'* [W 08]. Many believed that addiction, drug use, receipt of methadone maintenance treatment or even a history of drug use precluded the acknowledgement by society of the women's role, status and identity as mothers.

The women made serious and differing assessments of their mothering performance at different stages of their drug-using careers, lacked confidence and were very critical of their parenting. On the other hand, some of the women, particularly younger women, were quite confident about their ability to parent and the absolute appropriateness of their involvement in mothering. Several of them, mothers of babies, even projected to the future when they would become grandmothers!

> *No one is going to take my child away from me.* [Jenny]

> *I'm their mother, I gave birth to them, I'm the best for them to be with. I've always looked after my own kids. Like my mother didn't rear them.* [Marina]

This contrasted with the words of other women, who felt constantly threatened.

Whether successful or not, the women encountered all recounted that they wished to be good mothers and to be perceived by others as good mothers. While their definitions and descriptions of good mothering and parenting values and styles were similar to those of non-drug-using mothers in

other studies discussed earlier, several workers reported the mothering performances of drug-using women generally as beings at odds with their definitions and not meeting professional workers' expectations or standards. Regardless of the definitions of good motherhood, all stressed that they would prefer to be non-drug-using mothers but at the very least *'cleaned up'* or drug-free mothers. This was largely attributed to their perceptions and experiences of the impact of drug involvement on the motherhood identity, status and role. Overwhelmingly, however, their concerns centred on actual, imagined or potential impact on their children of their drug use, identity as drug user or the involvement in a drug-using lifestyle.

There were many revelations about their mothering practices, attitudes and behaviours. The women expressed concerns and demonstrated much ambivalence and fear, not about being mothers *per se*, but about the quality of their mothering performance. They were often harsh in their assessments of themselves pointing out their deficits and lacked confidence about their adequacy as mothers, echoing findings of other studies (Baker & Carson, 1999; Colten, 1982; Hogan, 1998). In response to questions about their parenting capacity and competency, women asserted that they were good mothers, offering clear definitions of what they believed to be a good mother. However, further discussion often belied these earlier expressions of self-belief.

Nevertheless they rarely used the term *'bad mother'* to describe themselves or other drug-using women's parenting behaviours, skills or capacity. Perhaps as suggested earlier this term is an 'unspeakable notion' (Kearney, 1994: 6), one rarely used to describe any women. Yet in talking about the good mother and the good enough mother, the notion of inadequacy was always present. Women often said, *'I wasn't a proper mother then'* or *'I'm a better parent now'*. Many believed that by virtue of their involvement in drug use and other activities they are not good mothers and, it follows, not good women. They rarely criticised other women generally or other women drug users specifically and displayed a remarkable solidarity particularly with women who had lost their children to the care of relatives or to the State. They were generally anxious not to demonise them in order to present their own performance as perfect.

> *Don't get me wrong. I'm no bleedin' angel myself!* [Darina]

This finding differs significantly to the phenomenon witnessed in another study whereby women drug users mythologised the 'other mother' as a guide of how not to mother while using drugs (Murphy, 1992: 160).

Impact on Children - Rueful Reminiscences

> *I really gave myself a bad time about what I done over the years being on heroin, which way it affected me children. I didn't know it was hurting them. ... I didn't know that when I was going through all this madness but today I do.* [Emma]

The guilt that drug-using mothers feel about the possible, real or imagined impacts of their drug use on the children has been widely documented as have their feelings of inadequacy as mothers and

sense of failure as mothers (Boyd, 1999; Colten, 1982; Coyer, 2003; Goode, 1999; Hogan & Higgins, 2001a; Irwin, 1995; Kearney *et al.*, 1994; Klee *et al.*, 2002; McIntosh & McKeganey, 2002; Murphy, 1992; Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993). While it has been suggested that this sense of guilt about drug use while pregnant or parenting diminishes over time and that women return to drug use (Klee & Jackson, 1998), the opposite was evident among the women encountered during this study. Those who were drug free highlighted how their accounts of parenting while using drugs became less negative the longer they were *'in recovery'*. However, regardless of their current drug-using status, many women expressed feelings of inadequacy.

The women in this project all identified regrettable things they did or omitted to do while using drugs and parenting. They also discussed the impact of their drug use on their children's lives and speculated about its long-term effects. Generally they adopted a discourse of regret to describe their involvement in parenting and their identity as mothers while using drugs. In some cases, this also extended to the period where they were methadone maintained or drug free.

Using drugs in the context of motherhood was for many a source of shame. Emma described herself as *'acting, thinking, being childish'* and lamented *'what I'd put my child through'*. Some believed that being involved in drug use was immature and irresponsible. Others talked about realisations suddenly arrived at about *'what I put my child through'*. Marina, identifying herself as a *'proper mother'* stabilised on methadone, described the reaction of her eldest daughter when she was *'a drug mother'*.

> *Like Angela used to tell me she hates me, that I was a horrible mother and you know things like that. But now she'd you know say "I love you" and "You're a great mother". "You're the best mother", you know.* [Marina]

> *I'd say they were delighted because they seen me bein' normal and not a drug mother. They seen me as a normal mother, makin' their dinner, cleanin' up, you know.* [Darina]

> *She hated me! Yeah, for hurting her like! I didn't realise I was hurting her that bad. But I did by my drug use. So now like she's grand. She's a completely different child now.* [Fieldwork contact]

Many talked about *'not being a proper mother'*.

> *You just can't do no wrong on the children. Although we were doing wrong on them but at the time they didn't know about it ...it wasn't right. Normal parents don't do that although there are... we were normal parents. ... We were their, we are their parents, we had to look after them and that was it.* [Sharon]

> *I loved looking after the children. It was ok for a while and then I fell into drugs again. It wasn't right.* [Arlene]

Many held low opinions about their parenting performance due to drug use. At moments there were silences during interviews and initially several women were reluctant to talk about parenting while using drugs.

> *I'm not going there...* [Ellen]

It sends shivers down my spine just talking about that ... tummy clenching stuff. [Liz]

However, they always went on to discuss their limitations, the things they felt that they lacked and the things about which they felt most shame. While rarely referring negatively to other women or mothers, several, now stable on methadone or drug free, described the impact of seeing women currently using drugs. They reminded them of their experiences.

Sometimes I see a woman and she's shouting at her kids and I think I was like that. Oh God I can't bear it! [Emma]

You know, when I see women pushing buggies around out looking for drugs and their kids with them. I did that too. [Darina]

Some described how their drug use was normalised within the family system, their children knew about it and accommodated it. Others mentioned how their routines became disrupted due to drug use and the life associated with it. Some acknowledged that there were days when their children missed school or they went to school alone as they were unable to get up in the morning.

Well they just got so used to me taking them. My children would say "get Mammy's tablets" when I was real cranky and narky. My kids got to know when I was sort of detoxing off them or not having enough drugs in my system. [Frances]

One of the things that I feel most guilty about, where it impacted on my parenting, was the having to run around and hustle for the drugs and having to take the kids with me. I feel guilty ... that I left them on their own sometimes, that I dragged them with me waiting in the cold and the problem there was having to go out and chase the drugs because I couldn't access them anywhere except on the street. [Liz]

They also suggested that when heroin was scarce and they were experiencing withdrawals that this was the most difficult time. It was hard to cope as children cried for bottles, breakfasts, and needed their nappies changed.

My parenting was so bad! I really like I literally had to have a drug before I'd get up and change his nappy. [Andrea]

Several women identified their children's, usually daughters' anger as they took over *'little mother'* roles. Their own childhood experiences of parentification, 'surrogate mothering' and the 'little mother' role were related in earlier chapters. Many claimed that they wished to *'do it differently'* with their own female children. However, some described gendered expectations for their daughters. Indeed, as noted earlier, several workers strongly emphasised the gendered experiences of their children, particularly focusing on the adult, quasi-parenting and watchful behaviours of girl children.

Significantly, despite experiences as *'little mothers'* during their girlhood, few raised their gendered expectations of their own children without prompting. Perhaps this was one area in which they resembled their mothers most. Almost 30 workers (75%) interviewed mentioned transgenerational issues, some specifically referring to gender issues in inner-city areas.

It's almost like traditional, it's very old-fashioned. But that the women and the girls, the expectations, like a lot of it is expectations on girls growing up ... there's almost an expectation that the boys are going to be out on the streets, getting into trouble and the girls are going to be looking after others, the carers. [Social Worker, W 37]

I definitely notice a gender difference. I think it's about identity and modelling. I think they emulate. [Social Worker, W 32]

As discussed in Chapter Six, many professional workers were pessimistic about whether the women could withstand the transgenerational impacts and about such supports provided to them to facilitate these changes.

And this is often of course a fantasy they have because what so often happens is that the baby is going to have exactly the same life ...it's almost trying to right a wrong that was done. I'm not saying they're bad parents. They're not! A lot of them are very good parents but it's just that they need to be reassured in some of the basics they have and that isn't happening. [Medical Practitioner, W 30]

Some women described the experiences of the girl children, which sounded remarkably similar to their own as children. Despite the women's understanding of their own gendered experiences as girls and *'little mothers'*, they also were gendered in their responses to their girl and boy children.

What you were saying a minute ago about daughters. Like I have a son, right, and the way I am now with my fella, right, he doesn't have to do anything. I do everything for him. So I hope that my son gets a fuckin' eejit ike me to look after him. ... If I had a daughter I'd try an' keep her away from them sort of men! [Focus group participant]

I have a son too and I'd like him to be pampered too. I'd like me daughters to be pampered 'cause they went through the mill. I think though we've a better chance of getting our sons pampered than our daughters. It's a man's world. The girls will take more shit than men. [Focus group participant]

Another interviewee described her five daughters as *'little mothers'*.

My kids look after me. They look out for me. They know about the drugs, the HIV, their da's death. You know Linda used to sit with me. Linda was the Mammy and I was the child because I was so dazed that their Da was dying. ...But they watch me too and if they see someone they don't trust and they think I'm up to something, they're straight down to me Ma's door. Between me kids and me Ma, I can't move!
[Rachel]

This too was emphasised by professional workers.

We see kids watching their mothers . . . Definitely the girl kids take on an awful lot and they become the minder and the watcher ... You'll often witness them sticking with the mother, watching and moving the mother away ... They try to mind and they try to fix it. [Community Worker, W 04]

While *'doing it differently'* emerged as a theme in the women's accounts, it largely related to emotional connections with children, commitment to education and providing protection against abuse.

I'd teach her to be independent, I want her to be educated. [Alison]

Like hopefully personally I'd love me own daughter to grow up, be independent, be educated, have a good job, do you know what I mean? [Susie]

The women were aware of the possible impacts of their drug use on their children and rarely minimised the effects in interview. Almost all clearly recognised the impact and harm that their drug use may have caused their children. In addition, almost all the women acknowledged that their drug use may have impacted in various ways and to different extents on their children and at moments on their parenting capacity and performance. None, except for those with babies and very young children, claimed that their children did not know about their drug use. In fact, the vast majority believed that their children had a right to know and *'not be left in the dark'*. However, most women were able to ensure that their children did not witness drug taking or injecting. They may have seen their parent on occasion *'under the influence'*.

Where their children almost always became aware of their parents' drug use, many accounts suggested that children rarely directly observed injecting drug use. There is a definite taboo with regard to injecting drugs in front of children within the drug-using community. All the women without exception discussed this issue, several women recounting the rare occasions where this occurred. Notably, in an earlier Dublin-based study a sizeable minority (40%) of the children had witnessed their parents using drugs (Hogan & Higgins, 2001b). In this study, neither the women nor professional workers reported these occurrences as being everyday happenings.[122] Those, whose children saw them use drugs, were disturbed by this occurrence. However, parents reportedly managed to create a range of buffers to protect them from such events, as seen in other studies (Higgins & Hogan, 2001b; Richter & Bammer, 2000; Taylor, 1993).

Concerns were raised about the impact on children of the stigma of having a drug-using mother. Aware that their drug use was rarely a well kept secret in their communities, they feared that at best the identity of child of a drug-using parent or at worst *'junkie child'* might attach to their children and create stigma and distress. As a former user with HIV, one woman chose to be public in the media about her status and was aware of the stigma and prejudice associated with this. All women interviewees, focus group participants and street contacts were concerned about the possible exposure of their children to the risks of ridicule, bullying, exclusion and discrimination. Several mentioned that their children experienced bullying by other children.

> *The kids get it especially in this day and age where the favourite fuckin' schoolyard thing is "your ma's a junkie", even if the parent never took drugs.* [Janet]

Others described how their children were rarely invited to other children's homes after schools and they were often the last to be picked for inclusion in events, teams and activities. Every single woman interviewed and met in the course of fieldwork mentioned the risks of children being

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[122] It could be suggested that the women were reluctant to be open about this issue accounting for the small number of occasions on which these occurrences were reported. However, notably, the parallel or even greater taboo about drug use during pregnancy did not prevent the women from describing this use retrospectively, as seen in Chapter Four.

taunted and jeered by other children – *'your Mammy's a junkie'* or *'your Ma's got AIDS'*. Family members, workers and several adult children of women drug users echoed these accounts.

Many professional workers mentioned that children pick up negative stereotypical images of parents from others and from perceiving their interactions with others, such as the children's grandparents, foster carers, neighbours, treatment providers and even people in the street. Hearing relatives' conversation, neighbours' comments or overhearing conversations between professionals and their parents often increased children's knowledge about their parents' drug use. Interestingly, though much unsuitable conversation reportedly took place in front of children and while parents were often criticised for this, they were not the only ones who spoke openly and inappropriately in front of children. This researcher witnessed several occasions where professional workers and family members discussed confidential and serious issues while children were present.[123]

Almost all women participants believed that they had positive impacts and influences on their children's lives and behaviour and they thought that this would continue to be the situation in the future. Some argued that their drug histories qualified them as alert parents with teenage children. However, some worried about their own children's potential or future drug use and often expressed concerns about the environment where drug use was widespread and over which they felt they had little control, also reported in another study of drug-using mothers (Colten, 1982). Others acknowledged their over-protectiveness and possible resistance to their children growing up and individuating. Women, whose children were teenagers or adults, discussed some of the difficulties they had experienced with their children during teenage years.

Women consistently mentioned how they overcompensated with younger children because of guilt feelings around their non-availability to an older child while they were using drugs or because a child was placed with someone else.

> *I used to feel so guilty about what I'd put them through. I over compensated and was prepared to give them everything and anything. Then I realised that parenting isn't about giving them everything. Sometimes when you've had very little and lived with the poverty and all that sort of thing, that's the way you think. These kids needed me to be the boss, they needed me to say "No" as often as I said "Yes". They're always great kids but they've got even better since I took control.* [Andrea]

The women's concerns about the impacts of their own over-protectiveness and the rejecting behaviour of their children's fathers may be far from unfounded. Their attempts to be less over-protective and to provide their children with a good father were insightful and demonstrated awareness of their children's needs.

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[123] In one agency a childcare worker was informing me about the crèche facilities on site and began to tell me about the parents of the two children present at the time. I found myself in an awkward position having to say to this very kind and welcoming childcare worker that the children were present and I would prefer not to be told things for the sake of my research over their heads while they played on the floor.

Several women expressed major concerns about parenting under extremely stressful conditions. The stresses were rarely related to drug use but often to dealing with difficult, sometimes physically violent and almost always emotionally abusive partners or ex-partners, who often monitored and undermined their parenting skills and performance. Evident throughout was the dearth of real material, moral or emotional supports for the women. Many parented alone as a result of separation, widowhood, or abandonment by common-law partner or their children's father. They persevered in parenting independently without asking family or services for assistance or support, as seeking help represented failure or an invitation for monitoring or harsh judgements. Current homelessness and accommodation in B&Bs or hostels, pressures from community and families, and ill health too were identified as causing major stress, as discussed earlier.

Others believed that they did wrong and have *'fallen from grace'* through drug use. Among the women, there were a range of opinions and views about their experience. Some felt guilt and shame generally because they were drug-using mothers and felt that they had done wrong by their children. Others felt guilt because they had used drugs during pregnancy and in some cases their children had experienced withdrawals after birth. Several women who had experienced the loss of children or pregnancies or any disability in children, no matter how minor, all felt that it was their drug use that contributed to or caused the situation. Thus, it is significant that those women who talked about guilt also talked about overcompensation and over-protectiveness in a manner, suggesting atonement and contrition for what they believed to be their transgressions with regard to drug use.

> *I'd explained things to them but I'd never actually said I'm so sorry. I did actually, one time I said it individually but not together. I didn't make a big haha. The next time an opportunity came up, I just actually did say that. "I want you to know I'm so so sorry for any of the pain that I inflicted on you".* [Liz]

They believed that they displayed some *'good mother'* attributes and practices at the same time as being *'not so good'*.

When the women responded defensively to workers' interventions, they sometimes minimised the impact, highlighted their victim status and defended themselves, contrasting their performance with other less successful drug-using or non-drug-using mothers. While they talked about the impact on their children, they mentioned specific issues such as not taking children to school or the impact of stigma on their children. They often viewed theirs and their children's experiences through the lens of guilt and were unsure as to how or if their drug use or their parenting actually had impacted on their children. Perhaps this is an outcome of defensive interactions with others. While reflective, however, they insightfully assessed the impact of their drug use and lifestyle on their children, as seen in this and previous chapters. However, despite all their attempts at ensuring that children came first and buffering the impacts of their drug use lifestyles and their treatment regimes, the women expressed regret about their past involvement in drug use. In general, they felt that they had transgressed in some way no matter how well they had protected their children. The burden of the guilt feelings associated with being mothers who have used drugs was onerous.

Colliding Discourses?

> Motherhood is contested terrain. Contested meanings of motherhood need to be understood in their social context ... The very term "motherhood" connotes a falsely static state of being rather than of a socially and historically variable relationship" (McMahon, 1995: 1-3)

The last sections highlight how varying views were expressed by the women and professional workers about whether drug use and motherhood are mutually exclusive activities. At points, this is precisely where there occur conflicting or colliding views. There are differences among women's accounts, among workers and in some cases between the women and the workers. These oppositionary accounts prove to be problematic and such varying and colliding views have been discussed at length in the literature review and methodology chapters. While triangulation and triangulated accounts (Denzin, 1978, 1989; Mason, 2002) allow for the inclusion of a number of viewpoints, voices and perspectives, it also problematises interpretations. It does not privilege or validate one participant's account at the expense of other participants' accounts or of the researcher's account. Retrospective memories may be vastly personal, one sided, exaggerated and have been questioned, as have accounts that have been influenced by treatment experiences or researcher effect (Rosenbaum, 1981a). However, it has also been the case that while self-reports by drug-using women have often been viewed as problematic (Barnard, 2005a), in fact much of our knowledge about parenting and the children of drug users and the 'bleak picture' portrayed (Tunnard, 2002a: 21) has actually been derived from women drug users' reports, rather than those of children or key workers.

The language used in descriptions of motherhood and parenting may differ significantly between the women and their families on the one hand and professional workers on the other. However, conversely, the women's performance of motherhood may sometimes be at odds with their mothers' expectations. There appears to be some conflict between the expectations of their families, communities and service providers. It is perhaps reasonable to tentatively suggest as some worker participants have that these conflicts are related to social class (Baker & Carson, 1999; Enos, 2001; Gillies, 2006; McMahon, 1995). Highlighting the differences in my study is crucial as it appears that the women had adopted a number of discourses to describe their involvement in parenting and a number of definitions of good parenting or motherhood.

It is also reasonable to suggest as many of the women's and professional workers' accounts have illustrated that the experience of under or unsupported motherhood described throughout may lead to many problems. It appears that the intersection of these two careers may lead to less rather than more support from all concerned for a drug-using woman in her motherhood role, a finding mirrored by other research findings elsewhere (Banwell & Bammer, 2006; Smarsh Hogan *et al.*, 2006).

Throughout, evidence of the women's preoccupation with issues of responsibility and respectability was present in their accounts, reflecting the findings of other studies with regard to this discourse of responsibility adopted by women drug users (Friedman & Alicea, 2001; Mayock, 2003;

Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993). The women's constant attempts to meet their responsibilities as mothers and maintain respectability as women and mothers within their families and communities were constantly challenged and often frustrated by the mere fact of their drug use. Many believed that the women's 'spoiled identity' was initially created and further reinforced by their interactions with family and services providers. This identity then affected their interactions with maternity services, public health nurses, social workers and other professionals, in some cases long after the drug career was concluded.

Because of their master status as drug user, it appears that many women have already categorised themselves as *'not so good mothers'* before they even become mothers and commence the performance. Some even questioned their right or the rights of other drug-using women to be mothers, to be custodial mothers and have internalised many negative views of themselves, mirroring the views of many participants in a US study of women drug users that to be good mothers, they must be drug free (Sterk, 1999a: 131). Guilt is a common theme. However, while reluctant to describe themselves as good mothers, many believe that they are fit mothers. Nonetheless, they all expressed their preference to be non-drug-using mothers and regretted their initiation into drug use. Even being a *'cleaned up'* mother presupposes *'once dirty'* and there is a strong adage of *'once an addict always an addict'* which may reasonably extend then to *'once an addict mother, always an addict mother'*. Even for those who became mothers after the end of a drug career the stigma of the *'once an addict'* notion was an issue.

Interestingly a range or typology of mothers materialised in the varying accounts of women and workers. Problems with identities and statuses emerge at every stage of the drug-using career. This continuum ranged from *'junkie mother' or 'drug mother'* to *'methadone ma'* and *'cleaned up'* mothers, always already 'bad', diminished or lacking something. *'Good mothers', 'bad mothers', 'monitored mothers', 'restored mothers', 'redeemed mothers', 'childless mothers'* and *'normal mothers'* were all mentioned frequently. There are suggestions from some, women and workers, that there are neither *'model mothers'* nor *'bad mothers',* while several others, a minority, suggested that there are *'disastrous mothers'*. Several women inferred that their mothering performance is modelled on that of their own mothers, some regarding their mothers as *'perfect mothers', 'good mothers'* or *'best mothers'*. Others suggested that their mothers struggled and that while they greatly admired their resilience, they wished to be *'different mothers'* and *'do it differently'*. Other mothers such as *'fit mothers', 'unfit mothers'* and *'the Holy Mother'* were mentioned and being *'Madonna-like'* did not refer to the American celebrity!

This study highlights the women participants' often under-confident and self-critical accounts of their involvement in mothering. Despite lacking confidence and while they aspired to be *'proper'* mothers, almost all argued that drug use *per se* did not impact on their ability to parent and resisted attempts to categorise them as *'unfit'* mothers. As the literature revealed, significant similarities between drug-using and non-drug-using mothers from similar socio-economic backgrounds in

terms of their aspirations and desires for their children, their definitions of good mothering, the impacts on their children and their child abuse potential have been identified (Colten, 1982; Hogan & Higgins, 2001a; Smarsh Hogan *et al.,* 2006). However, one significant difference identified between these two groups is the social support response to these women (Banwell & Bammer, 2006). By all accounts, the experiences of drug-using women in this study, whose descriptions of support are variable, are reportedly similar to their counterparts elsewhere.

Different drug-using careers and parenting histories were viewed throughout, highlighting the collision between the careers and the conflict between the women's views of their master status and the views and definitions of others. Which comes first – motherhood or drug use status? The women view and define themselves primarily as mothers. Almost all women regard their 'master status' as mothers, believing that this supersedes their status and identity as drug users. However, it appears that others in their social networks, social services and society at large regard motherhood as the women's secondary status, subordinate to their master status of drug user. They are regarded as drug users first and foremost, their motherhood role and capacity assumed to be detrimentally affected by their involvement in drug use.

Throughout this discussion and earlier chapters, participants' accounts demonstrated that the women's experiences of motherhood, their role, identity and status as mothers were affected by their other status – that of drug user. This area of differing understandings of drug use and motherhood, contested meanings generally about motherhood and conflicting moralities about responding to women in such situations is highly problematic and central to the intellectual puzzle proposed by this thesis.

What is essentially most problematic and contested in this discussion is how good mothering is variously defined and perceived by different interest groups. There appears to be some distance at moments between the women's perceptions and performance of mothering and the views and expectations of some of those around them, particularly social workers. While it is certainly reasonable to suggest that many may use a different language to describe the role of parenting, they may also be very unsure about what exactly is expected of them – traditional expectations, gendered expectations and professional expectations.

Conclusion

Earlier the women's and workers' accounts revealed how women drug users, their performance watched by partners, peers and relatives or monitored by services, were obliged to be 'exceptional mothers' (Rosenbaum, 1981a) and parent at a high standard to gain approval and preserve the motherhood role. In discussing this 'contested terrain', this chapter presented further revelations about their efforts to reconcile their lives as mothers and drug users. Women participants reportedly aspired to be good mothers, describing what they believed a good mother should do and this then dominated their experience of motherhood. Thus definitions of good mothers, bad

mothers, proper mothers and fit mothers were offered. They related how they tried to be a good mother and to avoid the label of unfit mother. However, many also believed *'deep down'* that a *'proper'* mother does not use drugs. Consequently, in their efforts to attain fit mother status, they described an overzealous performance and at moments a self-conscious and defensive style of mothering including overcompensation, over-involvement, over-protectiveness, to *'make up for the wrong I did them'*. While they knew about the notion of 'good enough' parenting. they felt that in the eyes of all they can never be good enough and believed that their mothering role had been variously challenged.

Their discussion of what good motherhood involved revealed their attempts to be good mothers or even good enough mothers, while their failure to attain the iconic Good Mother status, a failure assumed before they even commence their career in motherhood, is highlighted. In what could be described as confessional accounts, the women identified their strengths and weaknesses as mothers. Achieving motherhood was presented as redemption or an epiphany and seemingly was central to the narratives.

However, whether drug free, currently using or methadone maintained, without exception all the women expressed anxieties and regret about their dual status and identities. Without exception they would prefer to be non-drug-using mothers. However drug free women with a distant history of use also identified their experiences of stigma and the ignominy of a past career in drug use.

The next chapter presents conclusions about the women drug users' experiences of their motherhood role, revisiting the trajectory of preserving motherhood and examining the implications of findings for policy and practice.

Chapter Nine

Discussion and Conclusion:

A Trajectory of Drug-Involved Motherhood

> ...women heroin users have 'spoiled' the private sphere of 'domestic bliss' and the public sphere of social hygiene. In effect, women heroin users are polluted women *par excellence*. (Ettorre, 1992: 77)

In presenting diverse accounts of the women drug users' retrospective and contemporaneous experiences of motherhood, the foregoing chapters offer clear evidence of the impact of a woman's drug use on her identity, status and role as mother. In the introductory chapters, several seminal ethnographic, feminist and qualitative studies of women drug users' 'careers' in drug use were identified as influences (Boyd, 1999; Maher, 1997; Rosenbaum, 1981a; Taylor, 1993). Additionally, McMahon's 1995 study focusing on the 'moral career of motherhood', also taking its cue from Goffman's notion of 'career' (1961, 1963), was informative. Several studies specifically focused on women's involvement in drug use and visited their experience of parenting and childcare in the context of their drug use (Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993). Some more recent literature had also looked at the experiences of custody loss among women drug users (Kovalesky, 1997, 2001; Kovalesky & Flagler, 1997). Taylor (1993: 154) suggested that women drug users, like many other women, have two careers, one in parenting in the private sphere and another, a drug-using career in the public sphere. Whereas few studies had looked inquiringly at both experiences, this research in contrast aimed to explore such an experience.

An increasing body of work addressing the needs of drug-using parents, the needs of their children, the assessment of parental capacity and the dilemmas facing social workers, drug treatment providers and other professionals was reviewed at length in Chapter Two. While several studies in Glasgow and Dublin had recently focused on the parenting practices and the impact of parental drug use on children (Bancroft *et al.*, 2004; Barnard & Barlow, 2003; Hogan & Higgins, 2001a) and several Irish studies had explored the experiences of mothers in families affected by drug use (Duggan 2007; McKeown & Fitzgerald, 2006; Murphy-Lawless, 2002), the motherhood experiences of women users of illicit drugs however had to date merited little attention.

This study aimed to explore the motherhood experiences of drug-using women in Dublin. It was motivated by the lack of naturalistic or qualitative studies of such experiences while conversely there was increasing local and international interest in drug-using parents, parental capacity and the needs of their children. Specifically, it aimed to document their experiences of motherhood and parenting post birth, their involvement in the day-to-day tasks and processes of parenting, particularly aiming to highlight everyday accounts of doing motherhood, with an especial focus on exploring interactions with drug treatment and social work services. It also aimed to document

professional workers' perceptions of women drug users' experience of motherhood and competency with regard to parenting and to examine the dilemmas that might arise for both drugs workers and social workers in this regard.

Key research questions were posed about the participants' experiences as mothers with a history of drug use, professional workers' perceptions of women drug users' experience as mothers, the interactions between women drug users and professional workers and the tensions, differences and contradictions, if any, in the interactions and accounts of both groups. It was hoped initially that addressing these key research questions would highlight implications for service delivery to women drug users, their partners, families and children; provide impetus for the improvement of service provision to these groups and inform the development of services. A harm reduction perspective also informed this study.

This final chapter discusses the women's experiences of drug use and motherhood recounted throughout and the implications of this collision in the light of the literature and policy and practice. The trajectory of women drug users' motherhood experiences, presented at the opening of Chapter Four, revisited in Chapters Five, Six and Seven, is reviewed as are the principal findings. The implications of the findings for policy and practice with regard to harm reduction, treatment, social work interventions and parenting are then discussed and reflections on the research process are offered before concluding.

Preserving motherhood – A Reprise

A qualitative, exploratory, inductive study incorporating both emic and etic perspectives, the findings prioritised the worldviews, understandings and experiences of a large number of women and professional workers, including counsellors, social workers, community workers, nurses and doctors. Evidence was also gleaned from some interactions with several of the women's adult children and discussions with several male partners and family members. To reiterate, 60 interviews with 26 women and 40 interviews with professional workers were carried out, from which much of the material discussed was drawn. These accounts were augmented by data gathered from a further 44 women focus group participants and 135 street contacts; 60 professional workers focus group participants and contacts; and several family members and adult children.

Consequently, attention was drawn to a number of issues and themes that have important implications for understanding women drug users' experiences of motherhood, the impacts of their parenting involvement on their drug use, of drug use on their parenting careers, of interactions with partners, parents and professional workers and the outcomes for their motherhood careers.

This study identified the overwhelming task of the drug-involved women participants as that of preserving motherhood in the face of drug-related difficulties, disapproval, assumptions and stereotypical representations, witnessed in many studies reviewed in Chapter Two. According to

these academic accounts, it is not uncommon for women who use illicit drugs to be culturally portrayed in negative stereotypical terms as 'unfeminine', 'unclean' and 'immoral'. Nowhere is this more evident than when a woman is both a drug user and a mother, when the stereotype is expanded to describe a person who invariably gives priority to her drug use rather than to her children. The literature review highlighted how the images of women drug users underpin and impact upon approaches to treatment and care, particularly as mothers.

A grounded theory emerged from the data, a trajectory of drug-involved motherhood, charting their early journeys from observing, rehearsing and anticipating motherhood in childhood and teenage years to becoming drug users and mothers and beyond. Their early achievement of dual status - both as mothers and drug users - strongly influenced how they perceived themselves, how others perceived them and, it appears, how they performed the motherhood role.

The study describes how socio-economic status or social class, education, childhood experiences, victimisation, drug use, treatment, recovery, transitions to motherhood, performing motherhood and, in some cases, loss of children to the care of others impact upon how women drug users create identities for themselves as mothers.

All 205 women participants, 193 of whom were themselves mothers, described their experiences and understandings of motherhood. Collectively, the women had a total of 442 children. The 26 women interviewed had 64 children and were the principal carers of a further four. Being a mother, even where the opportunity of doing mothering was denied, was central to each woman's identity and status. Their stories of motherhood describe experiences across a lifetime of mothering involvement, ranging from raising their siblings, in the frequent absence of their own parents during childhood, to supporting their own sons and daughters' transitions to parenthood.

As the profiles of the women in Chapter Four and the Appendices demonstrate, this was a group of individuals with a diverse range of backgrounds, socio-economic characteristics, drug histories, criminal involvement, experiences of pregnancy, birth and motherhood. Further chapters reveal that they espoused differing views and opinions about a range of subjects. Some similarities, however, were evident. Many of the different experiences of the participating women culminated in similar challenging responses by partners, families, drug treatment and social work services to their involvement in mothering.

The focus and the structure of this thesis were dictated by the issues and meanings, which were salient for the women and professional workers participating. In order to understand the participants' description of the social processes through which the women became mothers, performed motherhood, defended motherhood and sometimes lost the role, on the basis of their accounts and the emerging trajectory, the experience was divided into a number of phases. The first involved observing motherhood, the second rehearsal for motherhood and the third becoming

a mother, all recounted in Chapter Four. The participating women's experiences of socialisation as young girls in childhood, observing and watching other women, their mothers, grandmothers and other peoples' mothers to see how to be a woman and mother in their community and society, were recounted. It also highlighted their rehearsal of such a role as *'little mothers',* their initiation into drug use and their transition to being or becoming *'real mothers',* as they became pregnant and gave birth. The challenges of drug-involved pregnancy and birth were recounted, demonstrating that this is where interest particularly turns to them as mothers.

The following four chapters described the experiences of the women at varying stages of both their motherhood and drug-using careers, revealing their aspirations to Good Mother status and charting their interactions with key actors such as their children, partners, families, drug treatment providers and social workers. Key moments, actions and processes such as performing, defending, justifying and preserving motherhood are illustrated while the actions of family members and professional workers in challenging, watching and monitoring motherhood are also described. The experiences of women who succeeded in preserving their identity, role and status are related as are those of women who have experienced the interruption or termination of their motherhood role, having lost some or all of their children to the care of others. These accounts highlight the conflicting discourses arising about motherhood.

The fourth phase involved the doing and performing motherhood. In Chapter Five the women's performance of mothering and their motherhood role, by all accounts one normally assumed to be natural and inevitable for women, at different stages of their drug-using careers was described. Considering the women's age range, drug and parenting histories were viewed at different life stages. Drug careers and parenting histories were often complex, starting at different moments. Their careers in use alongside parenting and their access to drug treatment were reviewed. The accounts of the women offered insights into a vast range of experience. Notably, careers and involvement in drug use were affected by pregnancy, parenting and related attempts to become drug free.

This performance often took place under the watchful eyes of others, family members, treatment providers and social workers. In Chapter Six, the monitoring or surveillance of that performance and the interactions between the women and those watching their performance were discussed. Workers expressed concerns on occasion. A small minority seemingly believed that drug use and parenting were incompatible and mutually exclusive activities. Others, the vast majority, believed that drug use *per se* does not necessarily impact on the ability to be a 'good enough' parent. Despite their ambivalence about methadone, most professional workers expressed a preference that their women clients either be stablised on this substitute drug or be drug free rather than using street drugs. The vast majority of women and worker participants argued that almost all services responding to women drug users employed gendered practices expecting conformity to gendered roles and expectations with regard to motherhood. Whether they achieved it or not, in the main,

family preservation was the stated objective of much of the work in which all social workers engaged. However many women believed that the inevitable outcome of interactions with social workers was the loss of the motherhood role, which was why they often determined to avoid contact with social services. A typology of workers – non-believers, pessimists, pragmatists and resisters - based on their approach to and optimism with regard to outcomes for women drug users as mothers is offered.

In addition to performance, attempts at compensating for the drug-using status, and defending motherhood role as described in Chapters Five and Six, the women also were constantly challenged in their motherhood careers. This fifth phase or process, described in Chapter Seven, involved meeting challenges and defending the role. The women's experiences of defending motherhood when watched, monitored and challenged by parents, partners and social workers were recounted. In interaction with others, that performance itself often reportedly becomes defensive and the women described defensive, compensatory and protective strategies. All the women encountered experienced some challenges to their motherhood role, due to their youth in some cases, involvement in drug use in others, experiences of illness, mental health difficulties or homelessness in others again. The experiences of those no longer able to perform the mothering role, who lost or placed their children in the care of others, were also related.

Fifteen women experienced a sixth phase, which involved losing the role, while three women experienced a seventh phase when they retrieved the role. A range of experiences of drug-involved mothers, as custodial mothers, non-custodial mothers and mothers caring for some but not all of their children, is discussed. Many of those who lost custody of their children appeared to become further immersed in drug taking, often reportedly as a grief reaction or a coping strategy. Others, however, worked towards retrieving or recovering their motherhood role, attempting to prove through becoming drug free or stable that they may in the future be good parents, often with little success. In very exceptional circumstances motherhood was partially restored or retrieved. For all the women, the discourse of loss or potential loss of motherhood role and the loss of their children was central to their accounts. Some already mourned the loss, while others anticipated the loss and all feared the possibility of loss in the future. The discourse of recovery, retrieval or rescuing of the role in the future also underlay many accounts. This study witnessed how the women understood, imagined and negotiated their maternal futures. Some anticipated their future or lack of future as mothers.

A range of care and separation experiences of the children of the drug-using mothers in this study is also identified. A review of the children's living arrangements revealed that 27 of the 68 children to date resided with their mothers while 41 children experienced separations, sometimes on several occasions, from their mothers during their lifetimes. In addition, 46 children have experienced separations from siblings. Five of the 26 (19.23%) women interviewed at length in this project, three of whom were active and interested research consultants, have died since the end of

the fieldwork period. Collectively, they were the mothers of 14 children, some of whom were teenagers or already adults and parents themselves. This highlights the adversity faced by this group of women and their families.

Chapter Eight focused on the principles underlying the performance of 'good motherhood', highlighting specifically at the close the epistemological and ontological difficulties associated with such data generation. Whether drug use and motherhood are mutually exclusive activities was also explored. Whether drug free, currently using or methadone maintained without exception all the women expressed anxieties and regret about their dual status and identities. While many asserted their competence as parents, they simultaneously were concerned about others' perceptions of them as mothers and their mothering performance. With few exceptions and regardless of the impact of their drug use, they expressed feelings of guilt, regret and remorse about being drug users or their drug history, about their children, their shame, their undeserving nature, and often talked in terms of reform, change, and improvement in order to become better women, mothers, partners and daughters. They also expressed feelings of inadequacy, lack of confidence and insecurity about their motherhood role. The women often candidly expressed concerns about their children and the impact of their drug use and lifestyles on their children's welfare. While often reluctant to describe themselves as 'good mothers' because of their drug use, many believed that there was no question about their fitness to parent. Without exception they would prefer to be non-drug-using mothers. However, drug free women with a distant history of use also identified their experiences of stigma and the ignominy of a past career in drug use.

The women tended to define themselves primarily in terms of motherhood, while for many professionals the 'master status' was that of drug user. Drug use and mothering appear to be regarded by families and professional workers as incompatible, mutually exclusive categories, women using drugs constructed as 'bad' and 'unfit' to continue in the role unless they engage in treatment and ongoing contact and interaction with services.

Even while mothering they were concerned about the possibility of loss of the role and invariably described how they experienced their motherhood role, status and identity diminished or undermined. The accounts of women drug users and professional workers highlighted and described the women's immersion in a life of aspiring to, performing, justifying, defending and maintaining 'fit' mother status. Emerging throughout is the untenable nature of maintaining an active drug-using career and parenting once it becomes public knowledge. As mentioned at the outset of Chapter Four, five strategies were evident – learning the role, performing the role, defending the role and justifying the role and, above all, aspiring to be the 'Good Mother', in order to keep and maintain the role, in a word, preserve it. While the first two strategies are probably common to all mothers, the vast majority of women do not have to defend or justify their involvement in a role, which is regarded as 'natural' and 'inevitable'. Women drug users on the other hand believe that they must do so and are reported by professional workers as always having

to engage in these strategies. The women drug users' performance of the mothering role involves the management of two careers, identities and roles and the management of the stigma associated with a career in drug use. Their performance is often at cross-purposes with the expectations of families, community and those of professional workers.

The study describes how the women constructed motherhood, did mothering, managed mothering and negotiated motherhood against a backdrop of social and contextual factors such as drug use, poverty (in the main predating drug use), educational disadvantage, illness, lack of social, community and family support, lack of child care facilities and general adversity all of which impact on the motherhood role. However, overwhelmingly the impact of homelessness, insecure accommodation, long term residency in either hostel or bed and breakfast accommodation or the threat of any of the above was reportedly the key reason for many children of drug-using mothers living in the care of other family members or foster carers. Throughout, the impact of structural factors on the women's ability to parent and parent in a way defined appropriate currently by child welfare services and society at large is evident.

As highlighted in the literature review and throughout the findings chapters, an emphasis on women drug users' fitness to parent, the supposed incompatibility between careers in drug use and motherhood, and their perceived departure from traditionally appropriate mothering values and behaviours places phenomenal pressure on women, viewed as placing drugs before their children rather than self denying. This trajectory demonstrates one overarching process or narrative of preserving motherhood.

Discussion and Recommendations

> *I suppose the other thing that crops up, people being very, very worried about giving the history in case and they certainly are concerned mega ways about children being taken off them, more so I think more so now ...I just am very conscious of the fact that we get more women not giving the history, and then coming in and giving it late ... and there are others who give the history and become very concerned that maybe by giving the history they're going to put themselves in a child care vulnerable situation from the point of view of the child being taken off them.* [Social Worker, W 40]

The findings confirm that women drug users are faced with a range of challenges to their involvement in motherhood, as highlighted in Chapters Four, Five and Seven. Both their identity and status as mothers, without a doubt, are ambiguous and their motherhood role also is often threatened and is largely determined by their interactions with others, particularly service providers.

The epistemological and ontological dilemmas seemingly inherent in this study, reviewed in the chapters concerning literature and methodology and arising in the findings in Chapters Five, Six and Eight, give rise to a range of ambiguities that certainly confirm Kearney's (1994) claims that working with drug-using parents is a problematic and challenging activity, particularly for the social work profession. The dilemmas for professionals generally are separating out issues of drug use

from child protection or welfare concerns. On the one hand, automatic assumptions about drug-using parents, referred to throughout by women and worker participants alike, and uncritical acceptance of the overwhelmingly negative research findings are an easy refuge from having to carry out two parallel assessments simultaneously on drug use and childcare issues. In Chapters Six and Eight, it became evident that the assessment of parental capacity was unclear and often based on the master status of drug user, the workers' beliefs and often limited knowledge about drug use and drug users.

While ostensibly it appears that the debate involves two sets of actors – the drug-using mothers themselves and the professional workers (such as social workers, doctors, nurses, counsellors) - with diametrically opposing views, this is on the basis of the findings a rather reductionist and dicotomised overview.

The drug-using mothers' views of what it means to be a mother, in the main, mostly attach to a working-class view of motherhood articulated in instrumental language concerned with meeting basic, physical needs, also described elsewhere (Gillies, 2006; McMahon 1995) and emerging from their own experiences of having been reared by their hardworking and often unavailable 'double shifting' mothers and 'absent' fathers.

The second set of actors are those professionals (social workers, doctors, nurses, counsellors) who are less concerned with the meaning of motherhood than what they regard as competent parenting and whose professional ideology is informed by their professional socialisation and by the legislative and policy frameworks within which their practice is set.

From the perspective of the professionals, drug use by mothers constitutes an objective risk to their children in both physical and psychological terms in the present and for their subsequent adult lives. Drug-using mothers are frequently regarded as not consistently capable of identifying and meeting the developmental needs of their children in a mature and competent way, often seeing the children as being there to meet some need of the mother.

From the perspective of the mothers, it may be suggested that the monitoring of drug-using mothers and the assessment of their parenting practices reflect crude, moralistic stereotypes rather than professional competency and that such practices may also reflect gender and social class biases. This indeed has been suggested by many of the women and workers interviewed and is evident as a concern in the literature.

The collision of the drug use and motherhood careers explicitly explored in this thesis is reflected in the collisions in the research arena. Studies are often focused on women with little interest in their children and their motherhood role. In contrast, other studies are focused on the needs of children,

without concerns expressed for the needs of their parents, usually mothers involved in primary caregiving and with responsibility for the welfare and protection of their children.

Stereotypical images of women drug users abound (Ettorre, 1992; Rosenbaum, 1981a; Taylor, 1993), none more prolific than that of the drug-using mother as unfit to parent, as irresponsible, self centred, and uncaring about her children's needs (Campion, 1995; Klee, 1998; Perry, 1986). That some women drug users can and do combine both careers, while others fail to do so, is undeniable. Whereas some differences between the parenting practices of drug-using and non-drug-using women have been noted by some studies (Hogan & Higgins, 2001a; Mayes, 1996; Tunnard, 2002a), others have described the similarities between women drug users' experiences and the lives of non-drug-using women, particularly in relation to mothering (Baker & Carson, 1999; Banwell & Bammer, 2006; Boyd, 1999; Butler & Woods, 1992; Colten, 1982; Rosenbaum, 1981a; Smarsh Hogan *et al.,* 2006; Taylor, 1993). As the literature reviewed in Chapter Two suggests however, there is little sympathy for the drug-using mother and she is often categorised as unfit to mother and undeserving of support.

Several social work researchers have clearly demonstrated in their studies that interactions with drug-using parents create many dilemmas for social workers, in their assessment of parental capacity on the one hand and in their interventions and interactions with them on the other. As reviewed in the literature, some have argued that social workers do not hold punitive views of their drug-using clients and tend to try to be balanced in their assessments (Butler, 1996), while others have demonstrated a variety of views among social workers varying from extremely punitive to cautiously supportive (Adams, 1999; Akin & Gregoire, 1997; Buchanan & Corby, 2005). Irish and UK studies have shown that social workers and indeed drug treatment and family support workers are often underconfident, feel untrained and unskilled and lack role legitimacy, adequacy and support in terms of responding to this client group, particularly as parents (Adams, 1999; Billingham, 1999; Butler, 1996, 2002e; Duggan, 2007; Forrester & Harwin, 2004, 2006; Shaw *et al.,* 1978; Watters & Byrne, 2004).

In the light of representations of drug-using mothers as unfit or transgressing standards of motherhood (Scourfield, 2003) and the findings of this study, it is reasonable to suggest then that one of the main tasks facing women drug users is to preserve the motherhood role in the face of such disapproval.

Several studies (Enos, 2001; Kearney *et al.*, 1994; Knight & Wallace, 2003; Woods, 1994) provided snapshots of women drug users', residential treatment clients' or prisoners' parenting involvement at particular moments in time. However, in offering retrospective and contemporaneous accounts, this study documents the women's changing fortunes with regard to parenting throughout their lives. As seen in Chapters Four, Five and Six, the women were involved with parenting and often consumed by motherhood. In Chapter Seven, it became evident that some were fulltime caregivers

while others were 'part-time' mothers. Some had access to their children informally and regularly, where their children were in the care of a relative. In the cases of non-kinship care arrangements, the mothers were involved with their children on a limited basis through formal access and visiting. There were those who had custody of all their children, others who had lost all their children to the care of others and there were those who had lost full-time involvement in the care of one or some of their children. There were also several women who had retrieved their children from the care of others.

Indeed, it appears that the longer a drug-using or prison career continues, the less likely a woman drug user is to keep some or all of her children in her care, the more likely she is to lose her motherhood role and less likely to retrieve it. Also evident was the experience of women with larger numbers of children who faced various challenges or crises. The larger her family, the more likely she is to experience the loss of one, more than one or all of her children to care of others. Developing the trajectory and examining each woman's account revealed that the women's stories may possibly be far from concluded, as their careers or journeys in parenting continued.

For women drug users, whether custodial or non-custodial mothers, motherhood was reported as central to their identity, status and lives. However, for many mothering was not something they could or were permitted to do on a day-to-day basis for a variety of reasons. Many women were challenged in their parenting because of their involvements with crime, prison sentences, prostitution and homelessness. The originally proposed, and later abandoned, sampling strategy of including only those who were current custodial mothers would have precluded contact with many mothers, with diverse child custody experiences. Speaking to custodial mothers, it also became evident that some women's children had not always been in their care. In some cases, it was anticipated that loss of the motherhood role was impending or could occur in the future. Similarly some non-custodial mothers aimed for reunification with their children. Several of the 12 women, who were not yet mothers (as they described it) anticipated motherhood in the future, some were pregnant when encountered. All had views on motherhood.

It was clear that the women viewed this project as focusing on motherhood, and what it means to be a mother, rather than solely concerned with the day-to-day experiences of doing motherhood. While they described their average days as parents while using drugs, on methadone and drug free, they particularly emphasised the symbolic relevance of motherhood in their lives – experiences of having been mothered, becoming mothers, being mothers, being challenged as unfit mothers and losing motherhood.

On the basis of accounts offered by a range of participants and observation, it is reasonable to suggest that the women's experiences of motherhood, their role, identity and status as mothers was affected by their status as drug user. The findings of this study significantly challenge earlier claims about women drug users' successes at maintaining their motherhood role (Keenan *et al.*,

1993; Woods, 1994) and assertions about Dublin based social workers' non-stereotypical views of such women (Butler, 1996; Clarke, 1994). Several workers interviewed seemingly applied the lay master status of drug user and many respondents suggested that in the vast majority of cases social workers and other professional workers did experience a great deal of unease with regard to conflicting moralities and meanings of motherhood. In addition, many workers and women reported that the application of the lay master status of drug user was utilised by some professionals. At the close, we are left yet again with this unresolved dilemma about professionals' practice in assessment and support of drug-using parents and responses to women drug users as mothers. It appears that practice is often inconsistent, influenced by limited experience of drug users and drug use issues and the presence of lay attitudes and prejudices, as documented by other studies (Bates *et al.,* 1999). It was reported throughout by the women and workers interviewed that there is increased monitoring and control of drug users' parenting in the guise of care. This is occurring alongside decreasing support for difficulties with homelessness and securing family and child-friendly accommodation. Both, it is argued, have impacted on some women's ability to continue in full-time parenting.

The area of differing understandings of drug use and motherhood, contested meanings generally about motherhood and conflicting moralities about responding to women in such situations is highly problematic and central to the intellectual puzzle proposed by this thesis. As noted earlier in this chapter and in Chapter Two, many have argued that drug-using mothers are similar to other mothers in society in terms of their aspirations and desires for their children and their definitions of good mothering.

Both the literature reviewed and findings presented suggest that drug treatment often poses a range of difficulties for women drug users, not least those concerned with the practical realities of attending clinics while involved in childcare. A recent EMCDDA overview of drug treatment and drug trends in Europe suggested that harm reduction measures are failing women and that drug treatment services are still limited for women despite constant mention of their special needs (EMCDDA, 2006).

Also noted in Chapter Two, were the 'logical reasons and not so logical reasons' (Kroll & Taylor, 2003: 38) that lead to considerable scrutiny of alcohol and drug-using mothers. The literature demonstrated that while there are often major concerns about the impact of parental alcohol and drug use on the physical and cognitive development of children, much of the concern arises out of stereotypes about drug-using mothers as not aspiring to 'good' motherhood status. Differences have been identified in the nature and speed of social work responses to alcohol or drug-using parents, the latter meriting a more rapid and concerned intervention (Forrester & Harwin, 2004). Many professional workers, particularly social workers, are believed to equate illicit drug use with poor parenting or mothering capacity (Adams, 1999; Billingham, 1999; Boyd, 1999; Buchanan & Corby, 2005; Campion, 1995; Humphries *et al.*, 1992; Kearney, 1994; Maher, 1992; Mounteney &

Shapiro, 1997; Taylor, 1993). Some social workers' attitudes, knowledge and behaviour towards drug-using parents have sometimes been found to be discriminatory, limited, uninformed, pessimistic and not conducive to working with such a group (Adams, 1999; Akin & Gregoire, 1997; Bates *et al.*, 1999; Buchanan & Young, 2002; Klee, 1998). The dilemmas experienced by social workers have been identified by a range of studies (Billingham, 1999; Butler, 1996; Forrester & Harwin, 2004, 2006; Kroll & Taylor, 2003; Harbin & Murphy, 2000; Taylor & Kroll, 2006). These findings resonate with the findings of the present study.

As highlighted throughout the findings chapters, conflicting and contested meanings of motherhood emerged constantly between the women's accounts of their experiences and the workers' views of the capacity of the women as mothers. The participating women drug users' experiences of motherhood, and the responses of others to them as mothers, highlights how the notion of 'good motherhood' is socially constructed and determined historically (Baker & Carson, 1999; Enos, 2001; Gillies, 2006; McMahon, 1995; Phoenix, 1990; Phoenix & Woollett, 1991; Woollett & Phoenix, 1991). Also significant is how they attempted to define their experiences of motherhood and their definitions of good motherhood. Some women succeeded in using terms and definitions that meet many expectations, both working-class and middle-class. Other women talked simply about feeding, clothing, sheltering and cleaning their children. Some women participants' descriptions of good mothering as simply meeting children's physical needs may be somewhat different to the views and expectations of social workers with regard to the emotional, developmental and educational needs. However, a simple acceptance of this divergence in description as problematic may be counterproductive. As suggested in Chapters Six and Eight, this group of largely working-class women simply may not use the language required to satisfactorily and reassuringly describe their parenting practices in terms acceptable to social workers, the vast majority of whom presumably hail from a different background. What is deemed as socially acceptable mothering is often defined by those who also define what are the socially acceptable or unacceptable drugs and substances to consume – the 'professional' classes (Campion, 1995: 175). It is also clear in many of the women's accounts of their everyday activities that they focus more in their descriptions on instrumental tasks and the provision of physical care to children, as their mothers and grandmothers did before them, rather than on issues such as communication and emotional issues. In addition, the added burdens of having to meet, traditional, gendered and professional workers' expectations of mothering performance may create much confusion for many. Several categories of motherhood are suggested in these accounts, some which conform to traditional and gendered expectations of what motherhood should be and others that significantly diverge from what is regarded as socially acceptable or apt. Almost all are problematic, suggesting that a good mother/bad mother dichotomy simply undergirds all these accounts. It appears, however, to be unquestionably more subtle and complex than this simple binary categorisation.

As described earlier, the women believed that the drug use and motherhood activities collided, sometimes directly affecting their parenting and almost always impacting upon how they were

perceived by others. Some women, now drug free, described how early *'in recovery'* they considered that their parenting was poor while they were using drugs or on treatment. Retrospectively several challenged this self-critical stance, identifying it as a *'mantra'* of sorts. The women in question had been drug free for a long period and believed that their accounts about their parenting performance had changed over time as they have moved further and further into a drug free life. Viewing their retrospective accounts, memories and accepting their negative accounts of their parenting as absolute truth and their positive accounts as lies or problematic rather than contextualised and situated accounts coloured by their guilt and eagerness to reform, present methodological challenges. No doubt, as Barnard (2005a) suggests, these colliding moralities pose critical issues creating much discomfort for researchers. A lack of engagement with these issues and a passive acceptance that drug use equates with risky parenting ultimately may do harm and injury to participants and their children if uncritically applied to the development of policies and services. Public perception of participants and their children may be affected unfavourably by the publication and dissemination of such unqualified findings.

As evidenced in several accounts, social workers were claimed to view the women's overenthusiastic and overcompensating attempts to perform as mothers and to defend and justify their role in a negative light. Several professional workers, including drug workers, doctors, community workers and social workers, strongly argued that in the main social workers often lacked insight about how their interactions with the women were actually reinforcing these overcompensating and performing behaviours. This too was observed among the women in Glasgow (Taylor, 1993).

There was no doubt that some professionals unquestionably accepted stereotypical views of drug-using women as mothers and rarely questioned these sufficiently. While many workers posed rhetorical statements and questions about such stereotypes and perceptions, actual social work and drug treatment practices and interventions often conformed to stereotypical responses to 'unfit' mothers, regarded as 'unfit' precisely because they used drugs.

There was a tendency among a small number of worker respondents to generalise negative experiences with a few isolated cases to the entire community of drug-using parents as documented in Chapter Six, generalisations which some have claimed are 'unhelpful' (Campion, 1995: 173). Despite this, in the final analysis, there was little difference between the substantive issues raised by both groups of respondents. There were significant differences between and among the accounts of the women, a far from homogenous grouping. There were also significant differences between the accounts of professionals. Addiction counsellors and drugs workers differed in their accounts from other addiction counsellors and drugs workers. Doctors disagreed with other doctors, social workers were at variance with other social workers. It is noteworthy and evident in the findings chapters that workers were more systemic in their focus on structural issues. However in the 'public' arenas of focus groups with women drug users, rather than the 'private'

one-to-one in-depth interviews, the discussions focused less on personal experiences and the women became quite animated in discussing at length issues such as family systems, poverty, sexual abuse, prostitution, domestic violence, community issues, housing and homelessness.

Also evident was the dual nature of the women's responses to their socialisation as women. While they often conformed generally to gendered expectations of them as girls and women, attempting to be both respectable and responsible, they resisted definitions of themselves on the one hand as 'victims', helplessly 'duped' by men, and on the other as 'bad mothers' and 'fallen women'. Resisting the victim role then placed them in the role of villain, bad mother and fallen women. Their negotiation of these roles and identities, their wearing of one or the other identity or label depending on the audience and the constant conflict in their minds was described. The choice between victimhood or villain status often determined whether the motherhood role was successfully maintained and preserved.

A remarkable consensus existed among the professional workers about the lives of the women with whom they worked and their experiences as parents. Some of these accounts mirror earlier findings in an Irish context (Butler & Woods, 1992), and internationally (Boyd, 1999; Goode, 1999; Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993). While women take care of the business of child rearing, they are simultaneously involved with the taking care of the business of drug use. Their dual career status, often unacknowledged because of their involvement with the 'informal economy', is evident. Parenting involvement is highly gendered in terms of the division of labour and this too supports the findings of the abovementioned studies of women drug users.

The harm reduction project, often regarded as simply pragmatic, liberating and empowering (Ettorre, 2000, 2004; Rosenbaum & Irwin, 2000; Single, 1995; Wodak & Saunders, 1995), however involves post welfarist governmentality, surveillance and social control regarding drug users as diseased and possible contaminators of others (Keane, 2003; Miller, 2001; Rhodes, 1997). Specific questions have been posed about the harm reduction project in relation to women (Campbell, 2000; Ettorre, 2004). Ettorre (2004: 331) remarked that women are regarded as 'lethal foetal containers' and argued for gender sensitive harm reduction policies. Conversely, Campbell problematised harm reduction asserting that it is not a panacea for women drug users already regarded as doing harm to babies and children.

The women generally expressed a reluctance to use harm reduction services, such as needle exchange while using drugs. Women often were unable and less likely to seek in-patient or residential treatment programmes because of the lack of childcare and family friendly services to which they could bring their children. Their far from unfounded fears about reunification with children in kinship or foster care following completion of treatment dominated their concerns. Many had witnessed their friends and associates lose their children permanently to the care of others following such treatment.

If treatment services fast track women into situations where they are supervised, monitored and controlled for the welfare of others, foetuses and children, the eventual outcome may depend on the quality of the engagement and interaction with all the workers concerned. These concerns with harm reduction have also been raised by a number of commentators with regard to both pregnancy and motherhood (Campbell, 1998, 2000; Rosenbaum & Irwin, 2000). The nature of the interactions between the women as mothers and those who observe, judge and examine their parenting can either increase or reduce harms. Women's opportunities to chose and contribute to their treatment and care plans were often limited. The findings point to the importance of understanding the extent of resistance among the women, evoked by their perceptions of the services as controlling and labelling (Etherington, 2006).

As highlighted throughout and in the overview of the literature in Chapter Two, the lifestyle associated with illicit drug use has been identified as one which potentially may cause harm to children of drug-using parents (Barnard & Barlow, 2003; Harbin & Murphy 2000; Hogan, 1997, 1998; Hogan & Higgins, 2001a; Kroll & Taylor, 2003). However, despite drug involvement, many manage to parent, successfully maintaining their careers in parenting (Bates *et al.*, 1999; Buchanan & Corby, 2005; Campion, 1995) with or without supports and interventions from services. The literature and the findings suggest that there is a need for a triangulated and balanced debate on this issue which draws from focusing on parenting capacity, regardless of, in spite of or against a backdrop of illicit drug use; the needs of children; and the socio-economic context in which the women and children lives out their lives. While the child's needs must remain central and paramount, the women's needs as mothers and as human beings must be acknowledged. The risk of poverty and the impact of the socio-economic environment on childhood, educational attainment and exposure to drug use in addition cannot be ignored. The automatic assumption that women who use drugs are unfit, bad mothers, incapable of being good mothers simply demonstrates that assessments based on best practice are *not* being carried out. In the light of these views, it is reasonable to suggest that the lay application of the master status of drug user is being applied often without recourse to assessment guidelines, procedures and best practice.

Thom (1994) has highlighted how in creating services which are women sensitive in the alcohol field, aiming to assist them cope with their lives as women, that we may simply perpetuate a gendered state of affairs. Drawing on Moser's (1989) distinction between practical and strategic gender needs, Thom asserted that while it is important to develop services for women, simultaneously the gendered expectations that affect women's lives as well as the gendered nature of practices should be challenged and critiqued. Such a call has been reiterated in another research project focusing on women's experiences (Raine, 2001: 123). The social doings of the gendered system in relation to family, parenting, drug treatment and social work interventions are also challenged by my study's findings.

The findings have implications for the drug treatment and social work systems. There is a clear need for a policy focus which acknowledges women's existence and special needs, including their needs as mothers. These findings also indicate the rigid gendered nature of parenting and of the practice in drugs and social work agencies. These practices perpetuate the gendered experience of women drug users, particularly in their work as mothers. Drug treatment often focuses on encouraging women to adhere to or conform to what is viewed as their 'appropriate' gender and social roles.

It was observed that women drug users often defended their parenting conscious of parenting under the spotlight. While in defensive mode they often minimised the impact of their drug use, highlighted their victim status and defended their parenting, contrasting their performance with other less successful drug-using or non-drug-using mothers. Sometimes interactions with services reportedly elicited defensive behaviours, avoiding workers, minimising involvement with drug use and in some instances not looking for assistance, care and treatment when necessary. While in reflective mode, however, women often insightfully assessed the impact of their drug use and drug-using lifestyle on their children. This highlights the importance of services, which allow women to reflect on their practices. It also highlights the challenge for drug treatment and social work services to work less punitively and more supportively with mothers at all stages of their drug-using careers, in order to preclude alienating such women to the extent that harms to women and children, such as mother child separation, lack of family reunification and problems with access and mother and child contact following separation, are increased. This resonates with findings elsewhere (Klee *et al.*, 2002; Murphy & Rosenbaum, 1999; Rosenbaum & Irwin, 2000).

Statistics from one Dublin treatment centre[124] demonstrated that 19 children of their clients were admitted to care in 2001, 11 in 2002 and 18 in 2003. Of these, eight of 19 children were admitted to the care of family members and other relatives under Section 36 in 2001, five in 2002 and seven in 2003. Thirteen admissions were *'voluntary'* in 2001, seven in 2002 and 11 in 2003. However, at year end, all of the children remained in care in 2001 and 2002 while one child had been reunited with its parent/s in 2003. Five of 19 children admitted to care in 2001 were under one year of age, several indeed going straight into care from the maternity hospital. Seven of the eleven children admitted to care in 2002 and four of the eighteen children in 2003 were under one year. These statistics give rise to questions similar to those suggested by this study's findings.

The likelihood of increased drug-related and other harm to women drug users by virtue of their 'keeping mum' in order to preserve their motherhood role is evident as is the likelihood also of increased harm to their children. That both drug treatment and social work services' current unclear focus, master status driven assessment and increasing interventionist approaches may potentially

[124] Personal contact with the social work head and team. I would like to thank them for their kind permission to use this information before they carry out further analysis and research based on this finding.

further alienate and force underground mothers and children at risk is also evident. While it is beyond the scope of this thesis to tender detailed recommendations for policy and practice, a great many were suggested by the data. Indeed the study's findings confirm that the two careers of drug use and motherhood often occur simultaneously, sometimes creating difficulties and challenges for women, children, workers, and others alike.

This study suggests that while drug treatment and social work activities are conservative and reforming in nature, either punitive or disciplinarian, there is a need to develop a range of services that recognise women's roles as mothers. It is also suggested that there is a need to promote mainstream and specialist services for women drug users and their children that avoid an adversarial approach. Services need also to acknowledge women drug users' interests in and aspirations to belong in the world of 'work' beyond the work of parenting in the domestic sphere. The findings also suggest that easy solutions or answers to some of the thorny practice and policy questions that emerge remain in the main elusive; that drug treatment providers and social workers need to upskill with regard to childcare and drug issues respectively; review their assessment practices and constantly probe the assumptions they bring to the area in a reflexive and reflective way. Ultimately this study suggests that responding to drug use and motherhood in a formulaic or prescriptive manner is not possible and it is reasonable to recommend that workers be more questioning and probing in their responses, not just of the women's parenting and mothering practices and skills, but of their own therapeutic practices, beliefs and assumptions.

Reflections on the research process

Having completed the project and reviewed the process from beginning to end, before closing it is interesting to reflect on the research process, described at length in Chapter Three, addressing several issues such as the issue of truth, performance and the considerable lessons learned.

Validity and veracity

The issue of truth emerges in an interesting and problematic way throughout. In other drug-related research, for example, concerned with examining the little accessed world of drug taking and dealing, the women's accounts would be seen as credible first hand accounts about the ongoing interactions and processes within the street scene.

In accessing women drug users' accounts of their lived experience of mothering and motherhood, a sensitive, contested and controversial issue, their voices are the key voices in this project. They represent what some have called a 'view from below' (Harding, 1987; Mies, 1983), a group of people who have a 'master status' as drug users and deviants (Becker, 1963) and a 'spoiled identity' (Goffman, 1963) as women who are both drug users and mothers. The other group, the professionals could quite feasibly be described as a 'view from above' (Mies, 1991), from a place of acceptability and power. It was challenging to interview the professional workers. As examined by Duke (2002, 2003) in her reflections on the research process in her study of drugs, prison and

policy making, different issues in terms of representation and methodological challenges emerge when those interviewed are more powerful players within the 'official' world. Issues such as 'political correctness' and 'not going on record' arose on occasion when interviewing these respondents.

The selection of a number of data sources – women, workers and family members – lead to what have been described as multivocal arguments (Mason, 2002: 17) on the one hand, while conversely, having differing accounts from different groupings often appeared to divide the research down the middle problematically, throwing up a range of conflicting explanations and realities, at moments mirroring exactly the drug use/motherhood collision.

There may be an assumption on the part of many readers or practitioners that all accounts of drug users are inaccurate while the accounts of family members and professional workers are truthful, free of judgement, assumptions and agenda. Significantly as a result of her immersion in a study of the needs of children of drug-using parents, a study that involved the parents themselves, the children and kinship alternative carers as participants, Barnard (2005a) has problematised the epistemological position that all accounts can be treated as equally valid.

The epistemological position of those engaged with exploring the impact of parental drug use on the lives of children is almost diametrically opposed to that of the feminist, participatory and emancipatory tradition valuing the 'insider' account. Asking women to add their voices to those of the 'experts', however, within the discussion of women drug users' involvement in mothering challenges notions of expert knowledge and recognises the women's expertise and knowledge with regard to their experiences (Stanley & Wise, 1993). It also ensures a feminist perspective (Fonow & Cook, 1991; Lentin, 1993; Oakley, 1981) and aspires to a participatory and emancipatory model of research design and conduct (Gatenby & Humphries, 2000; Lynch, 1999, 2000; Reason, 1998).

In addition, crucially, it also challenges popular notions of drug users as unreliable witnesses. Some researchers have suggested that drug users may be inclined to remain silent about some issues, be secretive or omit to tell the whole story in an effort to present a favourable image (Maher, 1997: 216; Rosenbaum, 1981a: 147; Taylor, 1993: 23). One Irish commentator asserted that the typical drug user is manipulative, exploits situations and 'lies with great ease' (Comberton, 1989: 9). The validity of self-reporting among this group has been regarded as dubious (Barnard, 2005a; Mayes, 1996; Suchman & Luthar, 2000).[125] In studies about drug users' experiences of parenting this is believed to be even more so. [126]

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[125] As an interesting aside, it may be noted that the lie scale scores utilised in Smarsh Hogan *et al.*'s 2006 study of child abuse potential in drug-using and non-drug-using mothers revealed that contrary to their hypothesis at the outset, the lie scale scores for the non-user group were significantly higher than for the substance-using women in the treatment group. '[M]others who did not use substances were more likely than mothers in the treatment group to "fake good" responses' (p.153).

[126] Researchers often give themselves away as to whose accounts they most believe. In the introductory acknowledgements to their study of drugs, pregnancy and early motherhood, in which there is a

Yet despite concerns about truth and veracity in the accounts of drug users, other researchers have argued that the self-reported data of drug users about a range of behaviours can be trusted (Anglin *et al.,* 1993; Klein *et al.*, 2007; Sterk, 1999a; Taylor, 1993). Indeed, many researchers acknowledged that almost all that is known about women drug users' practice and attitudes towards parenting has emanated from ethnographic studies based on self-reports (Kearney *et al.*, 1994; Mayes, 1996; Suchmann & Luthar, 2000). Similarly many studies of the impact of parental drug use, the vast majority of which has been shown in Chapter Two to identify or place most emphasis on negative outcomes, have relied on drug-using parents as key informants.

Retrospective accounts are often problematic. Several researchers (Rosenbaum, 1981a; Sterk, 1999a) highlighted how women often recreate their experiences influenced by insights gained during treatment. Similarly women may minimise their alcohol/drug use or criminal activities, underreporting their involvement in an attempt to protect their reputations and respectability (Heidensohn, 1996; Thom, 1986, 1987). Therefore, these are all mediated accounts of experiences lived through by the participant. It has been noted by several participants that women's accounts of their parenting especially in early recovery, where certain narratives are crucial to the ongoing momentum of remaining drug free, may in fact be more negative followed later by a mellowing of their self-criticism the longer they spend in recovery.[127]

Further questions revolve around whether participants' actions match their stories. Kearney *et al.* (1994: 359) posed this question in their study of crack cocaine-using mothers. With a view to balance, questions also arise about the accounts of professional workers, many of whom appeared to adopt a 'political correctness' about this issue, as identified specifically by one participant (Social Worker, W 37) and about whether professional workers' claims to hold non-prejudicial and non-stereotypical attitudes match their actions and responses to parents. As mentioned earlier, in his study of social workers' attitudes to this group of parents, Adams (1999) observed different responses when using different research instruments.

As several researchers noted about drug-using parents in their studies (Colten, 1982; Hogan, 1997; Hogan & Higgins, 2001a; Kearney *et al.,* 1994; Taylor, 1993, 1997), many of the women in this study appeared to be fit and adequate parents, performing caring tasks and displaying care and concern about their children. However, it was not the intention of this project to assess or establish whether women drug users are good, bad or mediocre mothers. Kearney *et al.* (1994)

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supplementary investigation of the views and experiences of personnel delivering maternity, drug and social services to women, Klee and Jackson (1998) suggested that the accounts of the services providers offered alternative perspectives of the service and increased the researchers' confidence in 'the veracity of our data'.

[127] The stories or narratives recounted again and again in the course of recovery have been identified as conforming to certain structures and patterns and are believed to be crucial to maintaining a drug free status (Denzin, 1987; Friedman & Alicea, 2001). It is for this reason that some of the accounts of drug users in early recovery recounted by participants in several studies are interesting (McIntosh & McKeganey, 2002; McKeganey *et al.*, 2002). While there are no doubt negative outcomes to be reflected upon, it is also rare to find many positive accounts of drug users' performances as parents or children's experiences of having been raised by such parents (Akin & Gregoire, 1997; Buchanan & Corby, 2005; Campion, 1995; Kroll & Taylor, 2003; Tunnard, 2002a).

believed that it was difficult to assume that mothering actions match accounts. Simultaneously they asserted that much that has been learned about women drug users' involvement in parenting and performance, often not positive, as parents comes from ethnographic accounts.

However the value of these data arises from their generation in interviews with both the women drug users whose lives are affected by these issues and professionals working in the field. With the interviewing of 40 professionals and focus groups and conversations with a further 60 who have had contacts during long careers with thousands of drug users, including many of the women participating in my study, it became clear that few, if any, of the things told to me by the 205 women in the course of fieldwork were unsubstantiated by either other women's accounts, by workers' recollections or by my own observations. Whose accounts are privileged? Whose accounts do we believe? These are the essential epistemological and ontological puzzles of this study.

Performance

As seen throughout, the issue of performance, performing motherhood and performing for services arose throughout the interviews, focus groups and observation phase of the fieldwork. Performance has throughout sociological history preoccupied many, none more so than Goffman (1959), in his symbolic interactionist treatise on the *Presentation of Self in Everyday Life*. In terms of research the issue of performance, both that of the researcher and that of the participants, also arose. Chapter Three outlined the conduct and performance of this researcher in terms of proposal, design, data generation, analysis and write up. Indeed the qualitative research process has been likened to a dance performance or choreographic episode (Janesick, 1998).[128]

The issue of performance is one that must be raised with regard to the accounts, the telling, and the narration of all the participants, the women, the professional workers and family members encountered. However, here researcher insider status, the length of time spent in the field, the numbers of people and the heterogeneity of those interviewed, and the repeated interviews were valuable in terms of dealing somewhat with the thorny issues of objectivity, validity and reliability with regard to the telling of stories as performance.

Initially, it appeared that many women were accustomed to telling certain stories, particularly in relation to drug use, initiation and treatment in a formulaic and standard manner. Indeed several women mentioned how researchers and workers were always asking them the same questions. So it is possible that they have rehearsed and now perform in a certain way to satisfy, please, tantalise, entertain, shock or amuse workers, researchers and journalists in some cases. A range

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[128] Janesick (1998) described the research design phase as warm up and preparation, the pilot study as the exercises and background work, the interview process followed by the analysis, interpretation and writing as the performance, improvisation and cooling down. This use of the dance performance as a metaphor for the research process is interesting considering my engagement with the issue of performance throughout. Similarly Dunleavy (2002: 198) likened the writing of a doctoral thesis to a rehearsal, direction and performance of a dramatic production also.

of different versions was observed – *'I am not to blame version'*, the fallen angel, victim version; the retrospective, exaggerated, *'everything I did when I was using drugs was awful'* version. There were the exciting stories of street life, emphasising the freewheeling, and villain versions. Sometimes all types of narratives emerged. Others attempted to resist these accounts. In order to observe the range of accounts and discourses, it was beneficial to carry out several interviews, meet participants regularly, ask different questions about different issues at different moments, some which the women acknowledged they had not been asked before, and conduct member checking interviews and focus groups.

Throughout I was conscious that this study only exists because the participants were prepared to *'tell on themselves'*, narrate, perform, and in some cases act out their stories and dialogue for me, as researcher. In doing so they may be further judged in the future. As mentioned earlier, the lack of control that the researcher may have over the uses of the final product needs to be acknowledged.[129] Significantly, at the close of their interviews several women mentioned that they believed that their accounts might simply reinforce already negative views *'out there'*, some believing that they are *'damned if we do one thing and damned if we do the other, we just can't win'*. With regard to the value of this work to society, policy makers and the participants themselves a number of issues were raised. One community worker [W 11] argued that while crucial to listen to and hear the women's accounts, conflicts abound as talking about their experiences will inevitably lead to further judgements.

> *It is hugely important to listen to them in terms of their experiences and how they have experienced being a mother and being a drug user and all of that stuff, and it is hugely important because again it is for them, very difficult because they know they are going to be judged, they know.*

Professional workers too were eager to be interviewed and a certain performance was also evident. Their performance, as Adams (1999) has suggested, may have been different in other contexts. Some professional workers also focused on the *'worst possible scenario'* when talking about drug-using parents. In an effort to counter this eventuality I asked workers to provide case scenarios and the numbers of such scenarios encountered.

Learning

The lessons learned during this research project were considerable. An inordinate amount of time was spent at the design stage and while careful planning certainly was crucial, Punch's exhortation to 'just do it!' was lost on me (1998: 156). His concluding words 'Just do it by all means, but think a bit first' (ibid: 180) held me up considerably. The political and ethical dimensions of the proposed inquiry in a contested and controversial field preoccupied me greatly. Instead of naïvely waiting for access through sometimes uncooperative agency personnel, snowball sampling for interviewees at an earlier stage might have been beneficial. However, the period of time spent planning minimised

[129] As Kearney & Taylor (2005: 6) pointed out, media misuse of their research findings among drug-using parents occurred.

the 'perils of not looking before leaping' (Porter, 1994: 67). Too many data were gathered and at moments the centrality of the research questions seemed elusive.

The value of insider status and insider knowledge in terms of access, sampling and recruitment was evident[130] and the belief that insider knowledge is synonymous with bias or lack of objectivity was challenged. Accessing drug-using women or mothers as participants may be difficult due to fears of losing children, issues of trust and the sensitivities of the issues (Kearney & Taylor, 2005). It is reasonable to suggest, given that trust is of paramount concern, that the outcomes from research carried out by those who find it difficult to gain access in the first place may not be as reliable and valid as in those where insider knowledge, status and even partial immersion in the community in question pertains. Even when accessed, women may be more protective of their situation and resist attempts to find out about them and are often harder to engage with when reached (Ardener, 1972, 1975; Rosenbaum, 1981a). Insider status ensured that there were few surprises in the study locale. Simultaneously I was not perceived as a particularly 'exotic' or 'university staff' type of researcher.[131] Despite this, because of perhaps exaggerated fears of doing harm and distressing women who were already living with crises around their motherhood roles, I postponed one-to-one in-depth interviewing for too long, preferring to observe in the most unobtrusive manner possible, interview professional workers and carry out focus groups. Participants in the main appeared to enjoy the experience as has been found elsewhere (Finch, 1984). Some women came back to me repeatedly to talk to me and update me about their experiences and progress and I spent longer in the field and gathered more data than originally envisaged. However, as Maher (1997: 232) aptly stated, 'there are no shortcuts to or through women's lives' and research, particularly ethnography, tends to be a 'messy business'.

Further Research

This study also points to the need for further research in several areas. The attitudes, knowledge, behaviours and practice of drug and social work professionals in terms of women drug use and parenting certainly merit further attention. Ethnographic studies and observations of drug treatment clinical teams, drop in centres, needle exchanges and other low threshold agencies, would be particularly useful to differentiate between views expressed and actual practice. A long-term observational study of social work teams responding to a diversity of cases, including those where drug use is an issue, would be particularly informative and build further on already existing work in the Irish and international contexts (Buckley, 1998a, 2002; Scourfield, 2003).

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[130] Several researchers attempted snowball sampling or recruitment through drop in centres, regarded as the most beneficial venue for recruitment (Kearney & Taylor, 2005), recruitment of peer interviewers and even recruitment of a significant number of incarcerated fathers (a captive audience literally) in one case to make up the numbers (Hogan & Higgins, 2001a).

[131] Attempts at impressing me did not occur frequently and when they did occur they did not last long. Insider status and my history as a worker ensured that I was either known already or given references by others for those I had not yet met. This allowed for opportunities to build trust.

In addition, qualitative research exploring the experiences of children and the now adult offspring of drug-using parents is necessary. With the exception of several studies (Bancroft *et al.,* 2004; Barnard, 2003), most the research has relied solely on parents, family members and other key informants to gather information about children's lives. Children's voices have not yet been heard and their experiences have only been studied through the eyes of adults who care for or work with them (Barnard, 1999; McTeigue, 1998).

Concluding Comments

> *Being a mother is the best thing I've ever done and the most important thing I'm going to do in my life. But I'm afraid a lot that I'll lose them 'cause I'm an addict. But I've lasted till now. But I know I've survived it all. And the kids, they're so great. Being a mother, there's nothing else.* [Fieldwork contact]

> *I think that women get a harder time. I think once they come to the attention of services, we have ideas as to how women ought to behave in our society and if they slip from that, from being like the Virgin Mary, they're gone! They're like the Mary Magdalenes aren't they? But they really do, and it's a harder fall and a bigger fall whereas maybe we just don't expect that much of men anyway.* [Social Worker, W 23]

Where others examined the 'troubled trajectory of drug involved pregnancy' (Murphy & Rosenbaum, 1999: 102), this study presents findings about the troubled trajectory of drug-involved motherhood. The contingency of being both a mother and a drug user was explored, as well as the challenges of being a mother involved with the treatment system. Separate drug histories and parenting trajectories overlapped, providing crucial information about the context of the women's experience. Throughout this thesis several key themes have emerged. Among these are the similarities and differences between the women's experiences; the experiences of adversity, victimisation and their struggles to parent; the ordinariness of their day-to-day mundane existence; the strong impulse to survive and resist; the need to perform for the watchers, partners, parents, professional workers; the need to defend, justify and ultimately preserve their motherhood role. This knowledge needs to inform policy, theory and practice.

The trajectory of preserving motherhood or keeping mum highlights the uniqueness of the woman drug user's struggle to perform for others, please her assessors and prove her fitness to parent. For those who use drugs, there were mixed responses to their fitness to parent. Despite acknowledgement of the importance of motherhood in the women's lives, often little was done to render this experience easier. Much of the time key actors in the women's lives seemed to be ambivalent about supporting a drug-using mother in her parenting, as seen in other contexts. To have done so would be construed as enabling continued drug use. Often families are committed to the children while being dismissive of the women (Barnard, 2003; Colten, 1982; Rosenbaum, 1981a; Taylor, 1993). Therefore, children were often viewed as a means to monitor a woman's drug use and lifestyle.

This study confirms that professional worker interest in women drug users tends to be closely related to concerns about child bearing and rearing. This study also demonstrates the women's concern about other peoples' perceptions and assessments of their adequacy. This interactional process determined their own views of their adequacy and performance in the longer term. Many had adopted opinions, which had been proffered by others. Other women however continued to resist others' assessments of their parenting performance. In doing so, they attempted to preserve their selves, their motherhood and womanhood identities and indeed the ability to resist challenges against the odds has been displayed by large numbers of women. In order to preserve their motherhood role and mothering involvement, the women managed a careful process of alternating between compliance on the one hand and on the other, a subtle form of resisting.

This study demonstrates that in the experience of many of the women participants and accounts of professional workers that the women achieved the status of adulthood through becoming mothers. In order to achieve womanhood they, like many non-drug-using women, made the transition from being childless to being mothers, thereby establishing a feminine identity, as suggested by other Irish and international research. While this is by no means a new finding, this study specifically documents the process and trajectory for women drug users of making the transition to this new feminine identity and the subsequent lengthy struggle to defend it and their motherhood status. It has explored how the study's women constructed motherhood, did mothering, managed mothering and negotiated motherhood against a backdrop of drug use, poverty, homelessness, illness and adversity.

In the light of the study's finding with regard to the living arrangements of mothers and children, their experiences and the emergence of the trajectory of drug-involved motherhood, this thesis concludes that women drug users are indeed different from other mothers in society. Unlike other Irish women, they are not regarded as natural and inevitable mothers. They continue, even in situations where a history of drug use is a very far distant memory, to struggle to maintain their identity as a 'fit' mother. For those who lost their role, they are seldom regarded as bereaved, forgotten or silenced. Drug-using mothers have an identity which is ambiguous and precarious, and which is largely determined by their interactions with others, particularly service providers and by efforts to perform, justify, defend and preserve their mothering role. The women's preoccupation with concealing their drug-using status or at least minimising their involvement with drug use in order to preserve their role as mothers is identified. This outcome, however, is anathema to the notion of harm reduction or the reduction of drug-related harm, particularly during pregnancy or parenting, where women may need medical attention, advice and intervention or social and family support. In effect a woman's master status as 'drug user' pertains always and subordinates the motherhood status. Finally, despite the richness and diversity of all the experiences described, one trajectory illustrating the major challenge of the drug-using mother predominates, that is, the struggle to preserve motherhood – Keeping Mum.

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APPENDICES

Appendix 1 – Addendum to Literature Review

Women's drug careers, partners, psychosocial issues and treatment involvement

As mentioned in Chapter Two, there is little doubt and substantial evidence to suggest that women's experience of drug use, initiation, drug treatment, the criminal justice system, the medical system is qualitatively and significantly different to that of their male counterparts. Both qualitative research of lived experience of women and quantitative studies of large data sets of women and of women and men have demonstrated differences between men and women in their drug use and associated activities and behaviours. However there are contradictory findings.

There is evidence both in the international and Irish literature that women use illicit drugs less frequently than men. Women, it is suggested, are often introduced to drug taking by men, mostly partners, who are their main drug providers in their ensuing drug-using careers. However some ethnographic studies of women drug users have identified their purposeful participation in the world of drug use and have stressed that women may have a more self-determining role in commencing drug use often providing for their males partners' drug needs.

Despite the focus on partners as responsible for women's introduction to drug use they are rarely studied unless looking at this issue, intimate partner violence or support and influence on recovery (Laudet *et al.*, 1999). Partners' involvement in co-parenting or other aspects of the women's lives have merited little attention (Klee, 1996, 1998). Interviewing both men and women drug users, Klee (1998) reported how couples involved in parenting were able to share the tasks of parenting and other studies (Klee *et al.*, 2002; Klee & Wright, 1999) revealed the benefits of a supportive partner. Some commentators have argued compellingly for an understanding of the importance of relatedness, relational aspects and caring in women's lives, some specifically referring to substance users (Baker-Miller, 1978; Bepko, 1991; Covington, 2002; Covington & Surrey, 1997; Finkelstein *et al.*, 1997; Gilligan, 1982; Gomberg & Nirenberg, 1993; Henderson & Boyd, 1992; Klee, 1996; Pohl & Boyd, 1992).

Little is known about the male partners of women drug users although is almost universally believed that their partners too are drug users. According to Klee *et al.* (1990) most male drug users prefer female partners who do not use drugs so it is possible to identify these male partners of female drug users as a minority of drug-using men. The ethnographic studies offered some glimpses as to the nature of the women participants' relationships and relatedness with male partners. These often focused on drug taking, pathways into drug use, raising funds for drug use, influences on drug-taking, prostitution, and impact on treatment outcomes. In terms of HIV prevention and interventions, Klee (1996:172) cautioned that

> there may be a danger of health professionals regarding the prevention issue as paramount and the woman's need for a sustained relationship as expendable.

This may also be an important concern in terms of drug treatment programmes. Klee also

suggested that there is little evidence of a drug-using woman being dominated by her partner any more than her non-drug-using woman counterpart. She acknowledged that women drug users want and need to sustain the bond with their partners and that drug treatment and HIV prevention strategies need to accommodate this.

The link between drug use and domestic violence has been explored by a number of studies. Theidon's (1995) account of women drug users' experience of partner violence during pregnancy posed interesting questions and reframed arguments as to whether the women's drug use or the experience of violence has the most impact on the pregnancy and new born baby. A recent US study (Sales & Murphy, 2000) examined the experience of physical, sexual or emotional violent events among 126 pregnant women drug users and focused on drug use both as a survival strategy and as a source of vulnerability to violence. Gilbert *et al*'s (2000) study of 31 women in methadone maintenance treatment programmes contributed further to the evidence that partner violence may be associated with HIV risk taking behaviours and drug use.

Laudet *et al.* (1999) studied men's influence on the treatment and recovery process of their crack/cocaine using women partners and found that while participating men held negative views about women's drug use and positive views about the women's involvement in treatment, their support for the women partners, however, was passive and inconsistent. There were a number of reasons or possible explanations for their resistance to involvement in family oriented treatment including, alongside the male partners' ongoing drug use in some cases, 'their desire to maintain the status quo in the relationship, possible focus on their own recovery, divergent views about treatment goals and the desire to minimize stigma by association' (p.607). Riehman *et al.* (2000) examined the experience of 266 cohabiting or married individuals in order to study the gender differences in the way that intimate partners influence drug treatment motivation. They found gender differences in the impact, the significance of partner support and progress greater for treatment motivation in women than vice versa. Riehman *et al.* suggested that having a partner in treatment increases women's desire for treatment while having a drug-using partner decreases women's readiness for treatment. Interestingly it was also found that economic independence from a partner is associated with increased treatment motivation in both sexes.

Several of the women specific ethnographic studies (Joe, 1996; Mahan, 1996; Maher, 1997; Morgan & Joe, 1996, 1997; Roberts, 1999; Rosenbaum, 1981a; Sargent, 1992; Sterk, 1999a; Taylor, 1993, 1998; Waterston, 1993, 1999) clearly suggested that women drug users are purposeful human beings and have a degree of agency in their lives, in their decision making and in the choices they make. Other studies (Biernacki, 1986; Faupel, 1991; Waldorf *et al.*, 1991; Neale, 2002) examining the lives of both male and female drug users, some with a gender sensitive focus, also demonstrated this purposefulness. Women indeed are like many of the male drug users whose lives and activities are described in the earlier work of the 1960s and 1970s (Agar, 1973; Becker, 1963; Preble & Casey, 1969).

Women drug users are reported to be less likely to be involved in criminal activities, especially drug dealing activities (Anglin & Hser, 1987; Hser *et al.*, 1992). However, a large number of authors have written about women's experience and participation in the illicit economy, street level markets and drug dealing and there is a great variety in the findings of studies and their interpretation (Baskin & Somers, 1998; Bourgois, 1995; Denton, 2001; Denton & O'Malley, 1999; Dunlap *et al.*, 1994; Fagan, 1994; Joe, 1996; Joe & Chesney-Lind, 1995; McCoy *et al.*, 1995; Maher, 1995b, 1996, 1997; Maher & Curtis, 1995, 1998; Maher & Daly, 1996; Morgan & Joe, 1996, 1997; Somers *et al.*, 2000; C. Taylor, 1993). A debate on this subject has given rise to a significant body of literature about women's liberation and their increasing or changing involvement in such activities in recent times, some authors suggesting that women are very involved at the higher levels of the drug trade and viewing women's increasing involvement in the drug economy as evidence of 'emancipation' (Baskin & Somers, 1998; Bourgois, 1995; Bourgois & Dunlap, 1993; Fagan, 1994; Inciardi *et al.*, 1993; Somers *et al.*, 2000; C. Taylor, 1993). However, other researchers challenge this 'convergence' thesis[1] and recognise the constraints and constructs of gendered power relations at this level, arguing that women are still less advantaged in the social structures of the informal economy as they are in the formal economy and where they are dealers they are almost always users too (Daly & Maher, 1996; Denton, 2001; Denton & O'Malley, 1999; Joe, 1996; Joe & Chesney-Lind, 1995; Maher, 1995b, 1996, 1997; Maher & Curtis, 1995, 1998; Maher & Daly, 1996; Morgan & Joe, 1996, 1997; Taylor, 1993). Again the tensions between victimage and volition or structure and agency as epitomised in some recent ethnographic work are evident here.

Many studies suggested that women drug users often work in prostitution and these careers and their impact are often studied (Blom & van den Berg, 1989; Bourgois & Dunlap, 1993; Boyle & Anglin, 1993; CG&WS, forthcoming; Goldstein, 1979; Inciardi, 1993; McKeganey, 2006; McKeganey & Barnard, 1992a, 1992b, 1996; Maher, 1997; Maxwell & Maxwell, 2000; Paton, 1999; Ratner, 1993; Sterk, 1999b). The advent of crack-cocaine generated a certain interest, perhaps voyeuristic, in women's drug use, sex for crack exchanges, prostitution and infection control (Bourgois & Dunlap, 1993; Inciardi, 1993; Ratner, 1993). Concerns with the associations of certain drugs, such as crack cocaine with hypersexuality in women, have been expressed and received a great detail of research attention during the 1990s (Inciardi, 1993; Inciardi *et al.*, 1993; Ratner, 1993). However, this hypersexuality thesis has been challenged by others (Bourgois, 1995; Boyd, 2002; Maher, 1997; Rosenbaum *et al.*, 1990). Bourgois (1995: 280) argued that the myth of the aphrodisiacal powers of crack is maintained by 'journalists, social scientists, dealers and addicts themselves' while Rosenbaum *et al.* (1990) also averred that male researchers have exaggerated the importance of sex in their studies (Boyd, 2002: 40).

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[1] The convergence thesis, elsewhere described as the emancipation thesis and discussed and debated variously by a wide range of researchers and commentators with regard to drug use, alcohol use and criminal activity (Adler, 1993; Baskin & Sommers, 1998; Bell *et al.*, 1984; Bourgois, 1995; Bourgois & Dunlap, 1993; Denton, 2001; Denton & O'Malley, 1999; Ettorre, 1992; Fagan, 1994; Maher, 1997; Robbins, 1989; Sargent, 1992) argued or speculated that sex differences in substance use and problems associated have decreased in recent years particularly in younger groups and those less committed to traditional roles. Campbell (2000: 27) suggested that '[t]he claim that women's demands for equality generate "gender role conflict" or "identity confusion" and so propel women into addiction recurs with remarkable regularity'.

Several studies suggested that women's income generating activities are by no means confined to work in prostitution and the sex industry (O'Neill & O'Connor, 1999; Taylor, 1993). However in the Irish context several studies pointed to recent changes in drug-using women's involvement in income generating activities and suggested that that more drug-using women are now working in prostitution (CG&WS, forthcoming; O'Donnell & O'Sullivan, 2001; O'Neill & O'Connor, 1999; Woods, 2000a)[2]. The health issues of women drug users, especially those working in prostitution, have attracted considerable attention both in Ireland and in other jurisdictions (Lawless, 2002; Metsch *et al*, 1999; O'Connor, 1996; O'Neill & O'Connor, 1999; Taylor *et al*, 1993; Ward *et al*, 2000). Concerns about women in terms of sexually transmitted infections and HIV have dominated many research projects giving rise to images of women, particularly women drug users working in prostitution or the sex industry, as spreaders, vectors, contaminators of both moral and social hygiene, dangerous, polluting and polluted (Ettorre, 1992; Gorna, 1996, 1997; Patton, 1990, 1994; Richardson, 1987)

Women's interactions with the criminal justice system have merited some attention from feminist criminologists also aiming to challenge 'erroneous assumptions' about women's involvement with crime and the masculinism of the field (Heidensohn, 1996).[3] Women's experiences of prison have also been documented (Enos, 2001; McCann James, 2004; Malloch, 1999; 2000a, 2000b). Other research has documented gender differences existing in incarceration patterns, criminal offences, length of sentences and imprisonment while mothering or fathering.[4] Judges often aim to keep families together so as women are usually the primary caregivers they may receive special treatment and sometimes evade imprisonment. Maher (1997) revisited some of these ideas in discussing the victimage/volition notions, structure and agency debate and women's initiation into and pathways in drug use careers.

Psychosocial and Health issues of women drug users

Also evident in the literature is an intense focus on women's health, particularly during childbearing years. Women are constructed as more in need of help, helpless and constructed as weaker, sad or mad rather than bad. Mental health issues, sexual health, blood borne viral infections, rape, sexual abuse, domestic violence and homelessness are some of the topics that appear with some regularity.

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[2] In the Irish context O'Neill & O'Connor (1999) suggested that there were as many as 400 drug-using women working in prostitution in Dublin at the time of publication.

[3] Heidensohn (1996:32) considered some ideas that are asserted about women and the criminal justice system. One is that the system is 'chivalrous' towards women and as a result they receive less severe punishments, sentences and treatment. Another purports that the system is sexist in that it reinforces sexually stereotyped notions of role behaviour and punishes women by its sanctions against sexually deviant women. The third notion is that the system is more punitive to women through 'kindly coercion'. She also focused on women's tendency to minimise rather than amplify their deviance, minimise their involvement with deviant activities and that in the main they resist deviant identities (1996: 16 – 20), arguing that this is 'probably, then linked to "appropriate" gender role behaviour' (ibid: 19). Methodologically this may be crucial in terms of interviewing women drug users.

[4] A recent examination of the drug courts in the US (Nolan, 2001) offered several compelling examples of chivalry, paternalism, sexism and censure in its transcripts of interactions between women drug users and judges.

It is argued that in terms of both illicit and licit drugs such as alcohol, but with the exception of tranquillisers, that women use less problematically than men (Ettorre, 1992; Oppenheimer, 1994; Thom & Waterson, 1989; Waterson, 1996, 2000). However when women use, it is maintained that they require smaller quantities of drugs and alcohol to become addicted or dependent on the substance and develop drug related or alcohol related health problems, particularly liver damage, sooner (Anglin, Hser & McGlothlin, 1987; Blume, 1992; Pohl & Boyd, 1992; Robbins, 1989; Thom, 1994).

Risk factors generally seem to be more pronounced for women, possibly because of social inequalities (Miller & Neaigus, 2002; Tompkins *et al.,* 2006; Travers & Bennett, 1996; Zierler & Krieger, 1998). Several studies concluded that women drug users are at increased risk and vulnerability of HIV infection as a result of injecting drug use, sexual contact and involvement in prostitution (Barnard, 1993; el-Bassel, Cooper *et al.*, 1998; Klee, 1993, 1996; McKeganey & Barnard, 1992; Taylor *et al.,* 1993). The gender differences in choice of partner discussed above have implications for risk behaviour with regard to HIV and other health risks. McKeganey & Barnard (1993) suggested that the sharing of injecting equipment is most likely between people with established emotional or social bonds. Women's needle sharing activities and the gender differences in use of exchanges has been documented in a widespread number of locations (Barnard, 1993; Brook *et al.*, 2000; Geoghegan *et al.*, 1999; Klee, 1993; McKeganey & Barnard, 1992a; Taylor *et al.*, 1993;). However it is significant that women, particularly those with children, seem to fear uptake of harm reduction services as opposed to demand reduction services (EMCDDA, 2006; Meier *et al.*, 2004). Women's vulnerability to Hepatitis C infection was highlighted in several Irish studies (Allwright *et al.*, 1999; Long *et al.,* 2001). Several recent studies also suggested that Irish women drug users' drug-related deaths have increased over the past decade (Long, Lynn & Keating, 2005; EMCDDA, 2006).

Studies have found that women drug users report higher incidence/prevalence of anxiety, depression, psychiatric disorder, other mental health difficulties and medical problems (Becker & Duffy, 2002; Griffin *et al.*, 1989; Robbins, 1989), sometimes tendered as a reason for initiation of use or progression to heavy use (Ettorre, 1992; Klee, 1997; Sargent, 1992). Women reportedly take on a more damaging and permanent stigma than men, which then leads to greater susceptibility to passivity and depression (Greenleaf, 1989; Lex, 1991; Rosenbaum, 1981a). Low levels of self-esteem, high levels of shame, guilt and stigma associated with their drug use and the impact of their use on their families have been described (Boyd, 1999; Colten, 1982; Reed, 1985; Rosenbaum, 1981a; Sterk, 1999a; Taylor, 1993; Woods, 1992). Rosenbaum (1981a) observed that once women 'fall out' they are likely to fall further or 'fall harder'.

Rape, sexual abuse, victimisation, domestic violence and other experiences of violence have also been studied among women drug users. Childhood traumas, including early parental loss and separation, have also been noted (Howe, 2005; Maier & Lachman, 2000; O'Neill, 1994). Some

studies pointed to experiences of abuse among women drug users (Friedman & Alicea, 2001; Neale, 2002; Sterk, 1999a) while a number of studies have investigated associations between childhood sexual and/or physical abuse and drug use. These provided convincing evidence of earlier onset of drug use, different treatment outcomes, difficulties and greater severity among those who have experienced such traumas (Browne *et al*, 1998; McKeganey *et al.*, 2005; Maier & Lachman, 2000; O'Neill, 1994; Rohsenow *et al.,* 1988; Wilson, 1998; Wincup, 2000). Of particular note, Browne *et al.*'s (1998) Dublin-based study of 52 drug users attending an outpatient drug treatment programme, 28 men and 24 women, found that 21.2% of respondents (11 individuals) acknowledged that they had been sexually abused while 23.1% (12 individuals) had been exposed to physical abuse and violence as children. The age of onset of illicit drug use was significantly younger in those who had been sexually abused – on average approximately three years earlier. In their study they found that significantly more women reported a history of sexual abuse. Others have examined the early childhood traumatic experiences of women and men drug users, later substance use, HIV risk and parenting outcomes (Marcenko *et al.*, 2000; Medrano *et al.,* 1999).[5] The link between drug use and domestic violence has been explored by a small number of studies, some focusing on the need to examine these areas together (Humphreys *et al.*, 2005) or noting women drug users' experiences of domestic violence (Powis *et al.*, 2000) while others have highlighted intimate partner violence during pregnancy (Sales & Murphy, 2000; Theidon, 1995) connections between partner violence and HIV risk (Gilbert *et al.*, 2000) and women's own use of violence against violent male partners (Rajah, 2006, 2007).[6]

Some studies discovered the importance of a home in the woman drug users' lives (Galaif *et al.*, 1999; Rosenbaum, 1981a; Taylor, 1993; Waterston, 1993, 1999), while the importance of secure and safe living arrangements in terms of reducing drug related and other harm was stressed in another overview of several studies (Maher *et al.*, 1996). Irish research (Cox & Lawless, 1999; Memery & Kerrins, 2000; O'Neill & O'Connor, 1999) has also highlighted some of these same issues. In the Dublin context, Cox & Lawless' study found a disproportionate number of women drug users either currently or retrospectively having experienced homelessness or the out of home situation.[7] Memery & Kerrins' study (2000) focused on a brief review of the Housing Miscellaneous

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[5] Marcenko *et al.*, (2000) interviewed 127 'low income' African-American mothers and found that childhood sexual trauma and age were correlated with severity of drug use in later life. A history of physical or sexual abuse was significantly related to psychological distress in adulthood and interestingly addiction was highly correlated with child placement. These findings suggested the need for collaboration between drug treatment agencies and child welfare services. Another US study examined the histories of trauma during childhood and the effects on risky HIV behaviours of 181 active illicit drug-using women (Medrano *et al.*, 1999). The researchers found 'very few statistically significant associations' but argued that this could be explained by a number of issues including childhood trauma having an indirect, rather than direct effect on HIV risk behaviour (p. 605). Despite little evidence of a direct causal effect, it was concluded that prevention programmes should consider past and current individual and environmental factors that influence HIV risk behaviours.

[6] In the course of an ethnographic study, exploring the lived experience of women involved in methadone maintenance programmes in New York City, Rajah (2006, 2007) gathered data about women's use of violence against violent male partners.

[7] Cox & Lawless' project (1999) was largely concerned with the harm associated with drug injecting while homeless. However their study revealed that 62% of those respondents who were out of home and active users were men while 38% were women. They also found that sleeping arrangements were highly influenced by gender, the men were proportionately more likely than their female counterparts to report staying in

Provisions Act 1997, their study based on qualitative data revealing that it is often the indirect as opposed to the direct use of this act which has affected drug users, rendering them homeless. O'Neill & O'Connor's (1999) study of 77 women drug users working in prostitution revealed that 35 women were homeless at the time of interview, one woman lived in a friend's home, while 21 were living with their families. At the time of interview 12 women were housed in the women's prison. As in Maher's study (1996: 202) it would appear that 'underlying imbalances of power continue to structure the positioning of women in the street-level drug economy and the cultural meanings that attach to female drug use and homelessness'.

Gender differences have been seen as crucial in impacting on families' responses to their drug-using members, the support received by male drug users predominantly from their mothers identified in several studies (Stanton, Todd *et al.,* 1984) differed from others that reported women's disconnection and isolation from families in some cases (Inciardi *et al.*, 1993) and increased family interest in their children in others (Barnard, 2003; Colten, 1982; Taylor 1993). It has also been suggested that women lose their social networks within mainstream society (Inciardi *et al.*, 1993). Conversely others found mixed experiences but also reported that support networks of family, community, friends and other women drug users are central or key players in the life of the woman drug user and to her survival and functioning (Colten, 1982; Maher, 1997; Rosenbaum, 1981a; Sargent, 1992; Sterk, 1999a; Taylor, 1993). However the 'double binds' experienced by women drug users, presented by the family support offered, have been identified as has the increased ignominy experienced by families of drug-using women, particularly those who are mothers (Barnard, 2003; Murphy-Lawless, 2002; Raine, 2001).

Women's experiences of range of psychosocial issues have been studied in many locations and there is significant evidence here that many issues affect women due to their social roles. Whether these psychosocial and health issues predate or are consequent to drug use is a moot point.

Treatment

Women's experiences of treatment and their relationship to services have invited attention from a number of researchers also. Issues with regard to women's access to and uptake of treatment opportunities, the obstacles to women's participation and involvement, outcomes for women, alongside interactionist studies focusing on the process variously provide interesting subjects for study. It is suggested that women's experiences of treatment are different to their male counterparts, that their agenda for treatment is often dominated by their own and treatment providers' concerns for their foetuses, children and families.

Among many writers there is a view that the world of treatment is dominated by men (Ettorre, 1992; Vogt, 1998). Programmes are often designed with men in mind, men's needs rather than women's

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hostels, while female respondents were more likely to report staying in a B&B or with relatives and friends. Of 190 individuals interviewed, only 7% reported that they had never experienced being homeless.

coming to the fore. It is also suggested that there is a lack of knowledge about women generally, but especially with regard to women's experience of treatment (Wellisch *et al*, 1993).

Gender differences have been identified in the take up of treatment and the development of a 'treatment career' (Grella & Joshi, 1999; Hser *et al.*, 1997; Vogt, 1998). It has been suggested that women drug users are less likely to seek treatment or come to the attention of treatment centres (Ettorre, 1992; Henderson, 1990; O'Hare & O'Brien, 1992; Parker *et al.*, 1988; Sargent, 1992; Taylor, 1993; Woods, 1992). However contradictory findings reported that women become addicted more quickly after first use and enter treatment sooner than men after a shorter career of use (Anglin, Hser, & McGlothlin, 1987; Grella & Joshi, 1999; Hser, Anglin & Booth, 1987; Hser, Anglin, & McGlothlin, 1987; Hser *et al.*, 1997). Reasons for entering treatment seem to be different for men and women, push or pull factors the distinguishing features. For men the route is often through the criminal justice system while for women the route is primarily through social workers and counsellors (Grella & Joshi, 1999). Pregnancy, birth, and children are often the major motivation for women to change their drug-using lifestyle and enter treatment, (Wilke, 1994; Wilke *et al.*, 2005)

Greater obstacles and barriers to women's involvement in treatment programmes have been cited, the most significant identified as emerging from women's socio-economic status and lack of resources, concerns and fears about childcare and the insensitivity and lack of response of agencies and services to women's alcohol and drug problems (Copeland, 1997, 1998; Copeland & Hall, 1992; Copeland *et al.*, 1993; Friedman & Alicea, 1995, 1999, 2001; Reed, 1985; Rosenbaum, 1981a; Sterk, 1999a; Swift *et al.*, 1996; Thom, 1994; Thom & Green, 1996; Waterson & Ettorre, 1989; Woods, 1992). Lack of services and facilities to support women in their parenting roles are identified (Grella *et al.*, 2006). Significantly as Rosenbaum (1981a: 6) stated

> While the ideology of women's treatment programs mirrors the notion of women's proper societal roles as mothers, wives, and homemakers, there are no childcare provisions for the addict-mother during her stay in treatment.

Treatment programmes have also been described as unable to meet women's needs because of their insensitivity to gender related and interpersonal group dynamics. Women often do not wish to discuss many personal issues within mixed group contexts (Hodgkins *et al.*, 1997; Nelson-Zlupko *et al.*, 1996). In addition men's dominance within groups (Reed, 1985; Saunders *et al.*, 1993), the inappropriateness of confrontational styles when working with women (Ettorre, 1992; Kearney, 1997, 1998; Nelson-Zlupko *et al.*, 1995), and reports of sexual harassment of women clients by male staff and clients alike (Reed, 1985) have all been cited as obstacles to women's entry to treatment and, once there, their ability to remain with the programme.

Obstacles and barriers to involvement in some services rather than others may have much to do with their social roles as women. Some studies indicated that obstacles exist for women in terms of the sorts of services they can access. It appears that women tend to use drug treatment and

demand reduction services, such as methadone maintenance programmes, detoxification or therapy, rather than harm reduction services, such as needle exchange or heroin injecting facilities. One such study, Meier & Miller (2000), argued that women attend treatment services sooner after commencing drug use than men and are more likely to use treatment services than needle exchange facilities. These findings lead to interesting speculation. It appears that proportionately there are more women in receipt of drug treatment programmes than men. Extrapolating from both international and Irish studies it is reasonable then to suggest that these differences arise both because of services' focus on or prioritising of women and women's reluctance to seek certain types of service specifically.

A woman drug user may be reluctant to seek drug treatment, never mind ante-natal care, because of fears that revealing her drug use status will lead to her children being taken into care (Butler & Woods, 1992; Lewis *et al.*, 1995; Shea, 1992; Taylor, 1993; Woods, 1992). As a result she may be out of reach of support systems such as counsellors, welfare workers and others as well as interventions in relation to health promotion and harm reduction (Klee, 1996; Lex, 1993; Rosenbaum, 1981a; Taylor, 1993; Woods, 1992). It has also been suggested that drug treatment agencies are simply not catering for the needs of the woman user (Butler & Woods, 1992: Dunne, 1995; Farrell, 2001; Nangle Connor, 2000; Reed, 1985; Rosenbaum, 1981a; Sargent, 1992; Woods, 1992) and that treatment programmes are often male dominated in their management, facilitation, focus and orientation.

While some suggested that outcomes are generally comparable between men and women (Grella & Joshi, 1999) and that there are often little differences in terms of the benefits of varying treatment approaches (Thom & Green, 1996), other studies demonstrated different treatment experiences and outcomes for women and men drinkers or drug users (Reed, 1985; Sanchez-Craig *et al.*, 1991; Saunders *et al.*, 1993). There have also been commentaries on the need for single sex services and delivery of support (Covington, 2002; Covington & Surrey, 1997; Ettorre, 1992; Hodgins *et al.*, 1997; Niv & Hser, 2007; Sterk, 1999a; Wilke, 1994; Woodhouse, 1992). Hodgins *et al.* (1997) and Reed (1985) reported that mixed groups are associated with more variation in interpersonal style for men while being more restrictive for women and that women show more variation in single sex groups. Sterk's (1999a) women participants recommended that inpatient treatment programmes should not be mixed gender. Whether women only or mixed gender, findings in terms of treatment outcomes are mixed (Niv & Hser, 2007). It is suggested that women may have better outcomes overall even where treatment may not suit them. In other contexts it is suggested that women in fact do less well.

It appears then that despite concerns about the need for services specifically meeting the needs of women, they remain elusive and few and far between. In the Irish context as reported in the first chapter, few if any childcare support provisions are provided for women with children who wish to access treatment either in the community or residential context. These findings about treatment are

confirmed by the EMCDDA overview of drug treatment and drug trends in Europe that suggested that harm reduction measures are failing women and that drug treatment services are still limited for women despite constant mention of their special needs (EMCDDA, 2006).

It also appears that the victim/villain dichotomy examined in Chapter Two impacts on treatment delivery to women. Thom (1994) suggested that responses to women substance users can take two forms in that they can either challenge the status quo and avoid the perpetuation of their socio-cultural roles as wives and mothers – a feminist response - or they can simply work with women to meet their needs in terms of continuing to or resuming the carrying out of these roles – a gender specific response. In a similar vein, Wellisch *et al.* (1993) categorised treatment approaches as drawing on either an empowerment or pragmatic perspective, in which women are either conceptualised and treated as purposeful human beings with the ability, skills and strengths to make changes in and decisions about their lives or in which women are equipped with or encouraged to acquire the skills that will permit them to make such changes. Wellisch *et al.* further argued that treatment programmes for women should focus on supporting them with issues concerning child care and their relationships with children, training, education and employment opportunities and their health needs. These broader agendas for treatment focus on a range of social supports, suggesting the importance of much broader needs than purely psychological and 'addiction' focused models of treatment. The need to keep context and environment in view was mentioned in several studies as women's social roles, poverty and lack of social supports often impact on treatment and recovery (Dumas, 1992; Ettorre, 1992; Wellisch *et al.,* 1993).

The process of treatment delivery has also merited some attention. Foucauldian notions of disciplinary power also inform some commentaries and analyses of women's experiences of drug treatment and other services with a framework by which to examine women's experiences (Campbell, 1998, 2000; Friedman & Alicea, 1995, 1999, 2001; Young, 1994). In their study of the experiences of 37 women on methadone maintenance treatment, Friedman & Alicea (1995, 2001) described the 'methadone enterprise' and the 'culture of the addict seeking help' as an even more oppressive one than the drug world or the larger society in which it exists (1995: 439) and maintained that their women respondents 'found they were refugees from both the conventional society and the heroin world'. The women who chose methadone maintenance found themselves punished as a result of their move from 'deviance' to 'safe deviance' (Friedman & Alicea, 2001: 131). Women's experience of accessing treatment, their resulting dependence on the social service and drug treatment system, their being 'processed through conventional institutions' (2001: 130) ensure that they are watched, observed and monitored by clinic staff or doctors. Friedman & Alicea documented interactions between women clients and service providers, demonstrating how women are 'abused and demeaned by the process' (p. 131) and simultaneously resist rules, regulations and stereotypes. Resistance is particularly pertinent in terms of the women's perceptions of service providers' views of their parenting. Rosenbaum & Murphy (1987) described women on methadone as 'not the picture of health' and problematised some of their interactions

with treatment providers. In Klee & Jackson's 1998 study the women participants viewed methadone as chronically addictive and were eager to undergo detoxification.[8] However Sterk (1999a: 143) highlighted her women participants' disappointments with drug treatment and revealed that none of the women managed to give up drugs or detoxify from maintenance programmes. Friedman & Alicea (2001) also observed the reported reluctance of clinic counsellors and medical staff to support the women in coming off methadone.

Others have been concerned about the relationship between treatment providers and women drug users specifically (Ettorre, 1989, 1992, 1994; Rosenbaum, 1981a; Rosenbaum & Murphy, 1987; Sargent, 1992; Taylor, 1993), and for drug users generally (Hunt & Rosenbaum, 1998; Neale, 1998, 2000, 2002; Shavelson, 2001). Several outlined the ambivalence, power and control issues that emerge for the women using services and the treatment providers alike. Taylor (1993) particularly focused on the relationship between the women and their social workers. Hunt and Rosenbaum (1998) focused on the accounts of both male and female drug users of the 'hustle' within the clinic, examined consumer perspectives on methadone maintenance treatment and further discussed the dynamics of the culture of seeking help. In a series of publications, Neale (1998, 2000, 2002) focused on and presented compelling reports of drug users' accounts, views and evaluations of their experiences of services, particularly prescribing services and methadone maintenance treatment. Shavelson's account (2001) of drug users' negative experiences in interaction with the treatment system in the US provided interesting reading for those who wish to assess the impact of zero tolerance and 'war on drugs' type policy. Women's perceptions of help providing services have also been reviewed internationally (Salmon *et al.*, 2000) and in an Irish context (Dunne, 1995; Nangle Connor, 2000).

Several researchers highlighted epistemological differences in studies that recruit either those in treatment or those outside of the treatment system. It is interesting to note that it has been claimed that women in the treatment system are viewed as having 'gained access and used resources' (Dumas, 1992: 905). In a discussion of case studies of inner-city women drug users in treatment, Dumas claimed that women are seen as having 'been discovered and brought into the system' (ibid.). However it appears from her use of language that women are passively brought in, rescued, discovered, saved, taken from the streets, somewhat echoing Klee's (1996) comments about attempts to rescue women. Furthermore, the impact of treatment and other systems on drug users interviewed, also a methodological issue, has been noted. For example, drug and alcohol users tend in their descriptions of their experiences to use and draw on a range of discourses and language, medical, psychotherapeutic, social work and legal terminologies (Denzin, 1987; Friedman & Alicea, 2001).

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[8] Indeed some on methadone – 38% - seemed more anxious to detoxify from methadone compared with 12% of those who were using street drugs. 36% said they would continue with street drugs compared with 10% who would continue with methadone (Klee & Jackson, 1998: 67).

While some focused on the benefits of treatment for women, others have problematised the treatment system, the treatment process and the outcomes of such interventions. Boyd (1999: 3) pointed out that the negative impact of the medical and social service professions on women who use illicit drugs is largely ignored by researchers, while Rosenbaum (1981a: 105) remarked that treatment and its structure may have 'deleterious' effects in that it may 'lock women into the heroin life by actualizing the "once a junkie, always a junkie" prophecy'. While Taylor (1993) did not focus on the interactive process involved in treatment contexts, she did point to women's inability to enter treatment programmes because of the lack of residential care opportunities for women and their children, a claim made by many. She also highlighted that asking for help of family or treatment providers may in fact place women at risk of losing their children (1993:140). Indeed in order to survive treatment women may minimise and understate their involvement in 'deviant' activities and may present as victims, leading to increased interest and monitoring, particularly for those involved in mothering. Friedman & Alicea (2001) also suggested that many of the processes and interactions within the clinic or treatment context are far from empowering, pragmatic or helpful. Treatment interventions have been described as 'enabling control' (Goode, 1999: 179) and 'postmodern progressivism' where coercive measures are presented as 'compassionate rehabilitation' (Campbell, 2000: 183). Rosenbaum & Murphy (1987) also problematised seeking help. While they suggested that seeking treatment represents 'a positive step towards living a more stable life', they however concluded that

> ... given the inadequacy of the drug treatment system and the high relapse rate for women, one may rightly ask "Is there life after drug use for women?"

These differing conceptualisations of treatment and women's experience of such treatment raise questions about women's lived experiences of a range of treatment modalities. The question – who is being treated? – may also be posed. Is it the woman, her family, her children? Whose needs are paramount? Questions such as 'Is "Treatment" the Right Way to Think about It?' as raised by Miller (2002) are rarely asked with women in mind. The treatment and therapy models and their efficacy or appropriateness to women are rarely questioned or problematised. It has been suggested that women are particularly vulnerable to the application of a disease model while others concurred in suggesting that this model is often experienced as too confrontational for women (Ettorre, 1992; Kearney, 1997, 1998). Wellisch *et al.*'s (1993) suggestions that treatment should be empowering or pragmatic with a focus on supporting women with childcare, education and training and health issues favours a social rather than 'desocialised' analysis and response. In Thom's (1994) view, services which recognise the women's roles in society but simultaneous challenge the gendered nature of those roles, need to be provided.

Few studies have examined women's qualitative experiences of treatment involvement. Quantitative studies of large data sets and treatment outcomes rather than qualitative studies of lived experience have been the focus of attention. Significantly a number of studies have noted women's determination to 'come off' both street drugs and substitution programmes (Friedman & Alicea, 2001; Sterk, 1999a). However many find their pathways out of drug use without

succumbing to treatment (Biernacki, 1986; Miller, 2002), a process that has been described as 'maturing out' (Winick, 1962) or 'natural change' (Miller & Rollnick, 2002).

To summarise briefly this appendix pertaining to women and drug use has focused on additional key themes across the literature, taking into account different types of studies, which range from treatment focused research to the ethnographic endeavours of other researchers, identifying many diverse findings and has highlighted the inconsistencies, different views and varying findings. The varying underlying attitudes, assumptions and images of women, elaborated upon in the literature review in the main body of the thesis, evidently impact on the findings.

Appendix II – The 26 Women Interviewed *

Alison, 25 years, mother of two children, one in formal kinship arrangement (with mother) and informally primary carer of two others. Maintained on methadone.

Amy, 34 years, mother of two children and foster mother of two children. Drug free.

Andrea, 31 years, mother of two children. Drug free. Has experienced loss of motherhood role of both children in the past.

Arlene, 36 years, mother of three children, 2 in foster care and one with father and paternal relatives. Maintained on methadone.

Avril, 25 years, mother of one child, in informal kinship arrangement (with mother). Using drugs.

Brenda, 39 years, mother of one child. Maintained on methadone.

Darina, 36 years, mother of three children, one in informal kinship arrangement. Maintained on methadone.

Elaine, 29 years, mother of four children, all in foster care. Using drugs.

Ellen, 40 years, mother of two children, one adult. Drug free

Emma, 30 years, mother of three children, two in informal kinship arrangement. Maintained on methadone.

Ethna, 36 years, mother of two children, both in foster care. Maintained on methadone.

Frances, 44 years, mother of four children, three adult. Drug free.

Helen, 23 years, mother of one child. Maintained on methadone.

Janet, 23 years, mother of two children, one in informal kinship arrangement with mother. Methadone maintained.

Jenny, 23 years, mother of one. Maintained on methadone.

Katherine, 30 years, mother of three children. Drug free.

Laura, 44 years, mother of three children, all adult. Maintained on methadone. Has experienced loss of motherhood role of all children in the past.

Liz, 40 years, mother of two children. Maintained on methadone. Has experienced loss of motherhood role of both children in the past.

Maeve, 21 years, mother of three, one in informal kinship arrangment (with sister). Using drugs.

Marina 27 years, mother of two children. Maintained on methadone.

Rachel, 39 years, mother of five children, all in formal kinship arrangements (mother, sister, brother). Maintained on methadone.

Sandra, 18 years, mother of one. Using drugs.

Sharon, 39 years, mother of six children, two adult and four in foster care. Maintained on methadone.

Sheila, 28 years, mother of three children, all in formal kinship arrangement (with sister). Using drugs.

Susie, 24 years, mother of one. Maintained on methadone.

Wendy, 24 years, mother of two. Maintained on methadone.

* All names have been changed in order to protect anonymity.

Appendix III – 205 Women met during fieldwork *

Women – interviewed – blue (26)
Women in focus group - green (44)
Women met in the course of fieldwork – purple (135)

U – using (74)
MMT – Methadone Maintenance Treatment (110)
DF – drug free (21)

442 children and seven foster children

Woman	Age	Drug use	Number of Children
Aileen	30	MMT	4
Alice	42	MMT	3
Alison	**25**	**MMT**	**2 (2 foster)**
Allanah	39	U	1
Alva	23	MMT	1
Amanda	31	U	3
Amy	**34**	**DF**	**2 (2 foster)**
Andrea	**31**	**DF**	**2**
Angela	37	DF	2
Anna	22	MMT	1
Anne	21	MMT	1
Anne Marie	34	MMT	2
Antoinette	23	U	3
Arlene	**36**	**MMT**	**3**
Ashling	32	U	2
Avril	**25**	**U**	**1**
Barbara	29	U	2
Beattie	41	U	2
Belinda	23	MMT	1
Bernadette	20	U	1
Betty	32	MMT	2
Breda	35	U	1
Brenda	**39**	**MMT**	**1**
Bridget	21	MMT	1
Brona	38	U	3
Camilla	42	MMT	4
Carla	40	MMT	2
Carole	35	MMT	2
Caroline	21	U	2
Cathy	20	U	1
Celine	21	U	2
Charlene	43	U	5
Charlotte	21	MMT	1
Cheryl	44	MMT	2
Christine	16	U	1
Ciara	26	U	3
Claire	29	U	4
Cliona	28	DF	2
Crona	38	U	1
Cynthia	24	MMT	2
Danielle	34	DF	2
Darina	**36**	**MMT**	**3**
Davina	36	MMT	2
Deborah	26	MMT	3

Dee	37	U	3
Deirdre	21	U	1
Della	18	U	No children
Denise	36	DF	4
Dervala	32	MMT	2
Diana	37	MMT	4
Doreen	30	U	2
Dorothy	41	MMT	1
Edel	31	MMT	2
Eileen	36	DF	3
Elaine	**29**	**U**	**4**
Eleanor	44	U	3
Elizabeth	24	U	2
Ella	22	U	1
Ellen	**40**	**DF**	**2**
Elsie	40	DF	3
Emer	21	MMT	2
Emily	41	MMT	2
Emma	**30**	**MMT**	**3**
Enda	36	MMT	1
Erica	27	MMT	2
Esther	35	MMT	2
Ethna	**36**	**MMT**	**2**
Evelyn	22	MMT	1
Fidelma	33	MMT	3
Fiona	28	U	2
Fionnuala	35	DF	3
Frances	**44**	**DF**	**4**
Gabriel	35	MMT	1
Geraldine	39	U	2
Gertrude	31	MMT	3
Gloria	37	MMT	4
Grace	31	MMT	2
Grainne	22	MMT	3
Hazel	18	MMT	1
Heather	17	U	No children
Helen	**23**	**MMT**	**1**
Helena	30	U	3
Helene	41	U	2
Hilda	32	MMT	4
Irene	30	U	2
Isla	35	DF	4
Isobel	38	MMT	2
Jacinta	28	MMT	2
Jackie	33	DF	2
Jane	20	MMT	2
Janet	**23**	**MMT**	**2**
Jean	20	U	1
Jeanette	36	MMT	5
Jemima	28	U	4
Jenny	**23**	**MMT**	**1**
Jessie	27	U	3
Joan	32	U	2
Joanne	32	MMT	3
Josephine	26	DF	2
Joyce	34	MMT	1

Julia	40	U	2
June	40	U	1
Justine	29	MMT	3
Karen	17	U	1
Karina	33	U	No children
Katherine	**30**	**DF**	**3**
Kay	38	MMT	No children
Laura	**44**	**MMT**	**3**
Lauren	34	U	3
Lena	28	U	No children
Lesley	42	MMT	6
Lily	21	U	1
Liza	35	MMT	4
Liz	**40**	**MMT**	**2**
Loreta	32	MMT	3
Lorna	25	DF	1
Lorraine	19	U	1
Louise	37	MMT	1
Lucy	19	U	1
Lynda	19	U	No children (pregnant)
Lynne	36	MMT	1
Maeve	**21**	**U**	**3**
Mags	32	U	3
Mandy	23	MMT	1
Margaret	17	U	No children
Margie	41	MMT	2
Marian	20	U	2
Marilyn	46	DF	2
Marina	**27**	**MMT**	**2**
Martina	22	MMT	1
Marsha	36	U	4
Martha	35	MMT	2
Mary	21	U	1
Maura	36	MMT	3
Maureen	25	U	3
May	31	MMT	3
Megan	39	MMT	3
Melanie	34	MMT	3
Melissa	40	DF	3
Michelle	20	MMT	1
Miranda	29	MMT	2
Miriam	31	U	2
Niamh	25	MMT	2
Nicky	40	MMT	2
Nicola	29	U	2
Nina	48	U	6
Noeleen	24	DF	1
Nora	24	MMT	3
Noreen	23	U	3
Norma	46	MMT	1
Nuala	19	MMT	1
Olivia	19	U	No children
Olwyn	41	MMT	2 (2 foster)
Orla	22	MMT	2
Orna	40	MMT	2
Pamela	23	MMT	2

Pat	21	MMT	1
Patricia	31	MMT	2
Patty	39	MMT	2
Paula	23	U	1
Pauline	22	MMT	1
Penny	38	MMT	6
Phyllis	37	MMT	2
Rachel	**39**	**MMT**	**5**
Rebecca	28	MMT	3
Rita	38	MMT	3
Roisin	18	U	No children
Roseanne	17	U	1
Roslyn	23	MMT	3
Ruth	21	MMT	2
Sabrina	35	U	4
Sadie	41	MMT	5
Sally	39	U	2
Samantha	24	MMT	3
Sandra	**18**	**U**	**1**
Saoirse	25	MMT	1
Sarah	22	U	2
Sharon	**39**	**MMT**	**6**
Sheila	**28**	**U**	**3**
Sinead	37	MMT	2 (1 foster)
Siobhan	22	DF	2
Sophie	24	MMT	1
Stephanie	25	MMT	3
Susan	26	MMT	2
Susie	**24**	**MMT**	**1**
Tanya	27	U	2
Tara	27	MMT	2
Teresa	24	MMT	3
Terry	20	MMT	1
Tessa	25	MMT	1
Tina	26	U	3
Tracey	38	MMT	2
Tricia	39	MMT	5
Triona	32	MMT	3
Una	38	MMT	3
Valerie	22	U	2
Vera	28	MMT	3
Veronica	25	U	2
Vicky	38	MMT	1
Violet	26	U	No children
Vivienne	34	U	4
Wendy	**24**	**U**	**2**
Winnie	23	MMT	No children (pregnant)
Yvonne	32	U	2
Zara	22	DF	No children (pregnant)

* All names have been changed in order to protect anonymity.

Appendix IV - THE WOMEN – A PROFILE

This appendix introduces the 26 women interviewed while describing in more general terms the other 179 women encountered either in focus groups or during fieldwork on the street. The mean age of the 205 participants was 30.09 years, their ages ranging from 16 – 48 years,[9] while the mean age of the 26 women interviewed was 31.07 years with a range of 18– 44 years.[10] Samples consisting entirely of drug-using mothers tend to have higher mean ages than samples of drug users generally, of women drug users who are not mothers or samples consisting of both mothers and non-mothers. In fact women in this study have a lower mean age and a broader age range than many other studies of drug using mothers[11]. Studies of women drug users who are mothers in the international context, showed similar age ranges and average ages to this study.[12]

Although a small minority of the women encountered did not fit the stereotype of the poor, working-class, inner-city woman drug user discussed in much of the Irish literature (Butler & Woods, 1992; Carmody & McEvoy, 1994; Dunne, 1995; Farrell, 2001; Keenan *et al.*, 1993; Lawless, 2002; O'Connor *et al.*, 1988; O'Neill, 1994), the majority of the women did. They had been reared in

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[9] Of the 205 women, 14 women were in the 15 – 19 age group, two of whom were under 18 years; 51 were in the 20 – 24 year group; 34 were 25 – 29 years and another 34 were 30 – 34 years. Forty-five women were aged between 35 – 39 and 27 were in the 40 + age group.

[10] One woman was in the 15 – 19 age group; six were in the 20 – 24 year group; five were 25 – 29 years and another four were 30 – 34 years. Six women were aged between 35 – 39 and four were in the 40 – 44 year age group. While the average age of the 26 women in this study was 31.07 years and the larger group of 205 women was 30.09 years, other Irish studies revealed that the mean age of drug users in treatment has ranged from 25.2 to 23.8 years between 1990 and 1994 and 23.6 to 25.7 years between 1996 and 2000 (O'Hare & O'Brien, 1992; O'Hare & O'Brien, 1993; O'Higgins, 1996; O'Higgins & O'Brien, 1994; O'Higgins & Duff, 1997; O'Brien *et al.,* 2003). The five-year review of treated drug misuse in the Greater Dublin area reported the decreasing average age of treated users between 1990 and 1994. In 1990 the average age was 25.2 years; in 1991 it was 25.5 years; in 1992 25.3; in 1993 24.5 and in 1994 it was 23.8 years (O'Higgins, 1996). In 1995 the first national report offered an average age of 23.6 years for those receiving treatment in the Greater Dublin Area (O'Higgins & Duff, 1997). Mean age of those treated in the Republic of Ireland during 1996 was 23.6 years; 24.2 years in 1997; 24.7 years in 1998; 25.4 years in 1999 and 25.7 years in 2000 (O'Brien *et al.,* 2003). Overall, the proportion and numbers of women seeking treatment has increased significantly between 1990 and 2000 as discussed in Chapter One. Although the average age of drug users appeared to be between 23 and 25 years in these reports, studies of women drug users in the international context, particularly those involving women who are mothers, showed similar age ranges and average ages to this study.

[11] This is perhaps due to vigorous attempts to recruit a heterogeneous sample with an emphasis on diversity, including women who were at that time using drugs, in drug treatment programmes or drug free. Theoretical sampling led to accessing the accounts of women, which described their lifetime experience of mothering. Some were young mothers with one child; others were older with several children. Several were grandmothers. Some had babies, toddlers or preschool children. Others had school-going children, teenagers and children who were already adults. Some women had children at various ages and stages.

[12] The earliest ethnography of women drug users (Rosenbaum, 1981a) described the life experience of 100 women, with an age range of 20 – 53 years and a median age of 28 years. Seventy women (70%) were mothers. Taylor's study (1993) of 26 women in Glasgow, 22 of whom were mothers, showed that the women ranged in age from 17 – 34 years and had an average age of 24 years. Sterk's ethnography (1999a) of 149 women in Atlanta, Georgia found that age ranged from 18 to 58 years with a mean age of 33 years. Some but not all of the women were mothers. For studies where being a mother is a criterion for participation the average age seems to be higher. In Murphy's 1992 study of women drug users' experience of pregnancy and motherhood, the mean age of the 77 participants was 34.2 years with a range of 20 – 58 years. Boyd's study (1999) of the experiences of 28 women in British Columbia, Canada involved mothers whose ages ranged from 20 to 51 years with a mean age of 35 years. The mean age of the 68 crack-using mothers in Kearney *et al.*'s study (1994) was 34 years with a range of 20 – 58 years. 32.1 years was the average age in Kearney's study (1996) of 14 women in recovery (age range 24 – 39 years), while 35.4 years was the average age in Suchman and Luthar's study (2000) of 69 drug-using mothers. In Murphy and Rosenbaum's 1999 study of the 120 women' experience of pregnancy, 85% of participants were between 22 and 35 years with a median age of 29.

inner-city areas[13], lived in local authority housing, as part of large families in which they often took responsibility for other siblings and as a result some attended school infrequently. Where the sample deviated from this norm, it was rare with several women hailing from middle-class Dublin backgrounds and others coming from a relatively comfortable rural background or a background overseas. Whereas no formal measure of socio-economic status was used, nevertheless much information about their parents' occupations, the women's participation in education, housing situations as children and adults, and their employment involvement was gathered.

Parents' employment histories were variable with many fathers experiencing unemployment or underemployment while mothers worked at a number of jobs, cleaning, trading and seasonal and sessional employment.[14] Parents' involvement in schooling was described as limited although the women's knowledge of the precise details of their parents' educational involvement and attainment was not extensive.

Most women reported their own early school leaving and poor educational attainment, 20 having left school on or before the then official school leaving age of 15 years and only four women leaving school with a qualification of Leaving Certificate or better. Among the 26 women, the average age of leaving school was 14.26 years[15]. Many reported experiences of suspension or expulsion from school.

Twelve women reported that their parents had separated during their childhood or teenage years[16] and 11 reported that at least one parent was now deceased.[17] With the exception of one woman,

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[13] 16 women were reared in the inner-city. Five were brought up in North Dublin, two in South Dublin, two elsewhere in Ireland and one in England. Several moved with their families of origin to the inner-city. Others moved later to the centre of the city to live in local authority housing or due to homelessness. At the time of the research, 23 women were resident in the inner-city, one was resident in North Dublin and two in South Dublin.

[14] In the main they came from a background where at least one parent was often unemployed. Of the 26 women's fathers, only six were constantly employed throughout their daughters' childhood. Twenty fathers experienced unemployment almost always or permanently. Largely their occupations were described as *'labourer'* or *'docker'*. On the other hand, most of the women's mothers worked at one or more jobs outside of the home during their childhood. Of the 26 mothers, only five were described as *'housewives'*, one woman specifically describing her mother as not working *'outside the home but she worked very hard at home rearing us'*. The other 21 women worked both in and outside the home, 19 as *'cleaners'*. Several mothers were involved in street trading alongside cleaning jobs and some supplemented their income and their families' resources through shoplifting.

[15] Two women had left school at 12 years. Eight women left school at 13 years. Seven left school at 14 years. Three left school at 15 years. Two left school at 16 years. Four left school at 17 years.

[16] One woman was nine when her parents separated; three women were ten years of age; two were twelve; two were thirteen; two were fourteen; one was sixteen; and one was eighteen and had just given birth to her first child. In nine cases the children stayed with their mothers, in one the children remained with their father, in another two the children went to live with their grandmothers. In all but one of the families where separation occurred, alcohol use had been problematic at some stage. However several parents who had been drinking problematically ceased drinking by the time the separations occurred. In other cases, alcohol was not a precipitating factor. Violence and allegations of abuse were identified in several cases and *'philandering'*, inadequate bread-winning and marital discord were mentioned repeatedly.

[17] At the time of research seven mothers and eight fathers were deceased.

whose mother died when she was 16 years old, others had not experienced the loss through death of a parent during childhood years.[18]

Parental alcohol use, particularly among fathers, was mentioned. Fifteen fathers had been problem drinkers during the women's childhoods. Five mothers had been problem drinkers, four drinking alongside their problem drinking husbands included in the group mentioned above, while one was the sole drinker in the family. Sixteen families in total were exposed to parental alcohol use. In one family, one mother also developed a significant problem with tranquilliser use and gambling. Other women reported that their mothers used tranquillisers and anti-depressants to cope but did not define this use as problematic.

22 women commenced using opiates during teenage years, 18 of whom were 17 years or younger. Age at first opiate use ranged from 12 – 32 years, the average 17 years. Four women experienced first opiate use at 20 or more years. Only three women reported never having been involved in criminal activity, 23 women describing varying involvement with 'criminal' activities during their drug careers.[19] Of those involved with criminal activity, 11 have never been in prison.[20] However, 12 women spent time in the prison system of varying lengths and recounted their experiences ranging

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[18] Many women met in the course of fieldwork mentioned the death of a parent during childhood. O'Neill's (1994) study of emancipator education in a Dublin based women's project profiled a group of ten participants and found that nine women had lost one or both parents through death before the age of 13 years. Childhood traumas such as early parental loss and separation and their consequences for well-being in adulthood have been noted among drug users (Maier & Lachman, 2000).

[19] Most of these activities started during teenage years. The women engaged in a combination of different activities, having involvement in drug related and non-drug related crime and in sex work. Alongside paid work, the women engaged in a range of drug related, non-drug related and sex work 'criminal' activities. Rather than being a 'reserve army' in the drug world (Maher, 1997), much of their work actually was done in order not only to supply their own drugs, but to support their partners' use also and in addition to meet their children's needs. The role of mother impacted on their involvement in criminal activities and often dictated how, where, when and with whom they committed crimes. It also impacted on the sorts of crimes committed. All 23 women were involved in non-drug related activities, 21 of whom were also involved in drug-related activities. Seven women were involved in sex work, alongside drug-related and non-drug related crime. Prostitution is an activity that has always been engaged in by drug-using women in Dublin. However, in comparison to other European and American cities this involvement seemed small. This is one of the major changes documented by recent Irish research and the accounts of women and professional service providers within this study confirm this also (O'Connor, 1996; O'Donnell & O'Sullivan, 2001; O'Neill & O'Connor, 1999; Woods, 2000). Only two women reported that they confined their criminal activities to non-drug related endeavours. Many also reported how they supported their own and their partners' habits while *'putting food on the table for children'*. On occasion they spoke of household arrangements, division of labour with partners, where they stayed at home and the partner went out or the partner stayed home and they went out to get the money. Some described successful partnership arrangements that often worked well. The women contacts and focus group members also discussed their involvement in a range of activities. Most respondents engaged in drug-related and non-drug-related hustles while using drugs, on treatment or drug free. Not all women ceased criminal involvement when they became stabilised or even drug free. Their involvement with a range of activities was often related to supporting their families.
Older women talked about their involvement with shoplifting, *'when there was less security guards on the shops'* [Amy], some specifically mentioning their own mothers' involvement with shoplifting to support families. A number of their own parents were involved in criminal activity before them. Mothers, by necessity, had to often be good shoplifters as mentioned by Arlene, Darina, Laura, Liz and Rachel, while several others alluded to it. Others raised the issue of their having to contend with poverty, low social welfare payments and incredibly high prices.

[20] Two women were never apprehended. Nine were apprehended, charged and convicted of various offences but received suspended sentences or *'got Probation'* in all cases.

from several hours[21] or one week[22] to cumulatively seven years. Several studies in the Irish context have identified how prison populations tend to be drawn from backgrounds where poverty, unemployment, deprivation, early school leaving, drug use and mental health difficulties predominate (Carmody & McEvoy, 1994; Connolly, 2006; Dillon, 2000; McCann James, 2004; O'Mahony, 1996) [23]

Family of origin size varied, the smallest family consisting of two children and the largest 15 children. The average family size was approximately 6.31 children. The 26 women had a total of 138 siblings between them. Thirty-two siblings, 21 men and 11 women, were also drug users. Other siblings were not drug users, although a minority of these was reported by the women as experiencing alcohol problems. The deaths of a total of 11 siblings, one of whom died during childhood, have occurred. Seven drug-using siblings died either as a result of HIV, Hepatitis C infection or overdose. The other four deceased siblings were non-users.

In total, 16 women had drug-using siblings, in two cases as many as five or six drug-using siblings. Ten of the 16 women were the only female users in their family while ten women were the only drug users in their families. Therefore 20 of the 26 women were significantly the only user or the only female user in their family.

In terms of marital status, 16 women were single, that is, they had never been married. Ten women had been married on one occasion each. Five women were separated, two in new relationships while the three others were not in relationships. One woman was widowed. With regard to relationship status, 19 described themselves as in a current relationship with a man[24], 14 of whom were currently living with their male partner. Most described themselves as heterosexual although several women talked about bisexuality. Several women met in the course of fieldwork described themselves as lesbian exclusively.

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[21] Sharon was imprisoned and almost immediately released. Although she had some criminal involvement in terms of drug-related and non-drug related crime, she was only ever charged with a public order offence and had a brief encounter with the criminal justice system

[22] Laura spent one week in prison. She laughingly stated that *'I was a good robber. I didn't get caught much'*. However she insisted that she *'only robbed for (her) addiction'*.

[23] Carmody and McEvoy's study of 100 women in the prison system during a two month period in 1994 showed how 71% of the women were brought up and were living in the inner-city area of Dublin and that 60 had used drugs at some stages, 22 of whom had used drugs for the first time under the age of 16 years. Opiates were the drugs most likely to have been used. 62 women were mothers, eleven of whom had at least one child in the care of the Health Board.

[24] Of those in relationships currently, eight women described their partners, several of whom were in prison or had been recently released from prison, as current users. Three women's partners, one of whom was in prison, were methadone maintained. Two women were in relationships with men who were former users. Six women were in relationships with drug free men who had never used drugs. The 26 women's 64 children had a total of 34 fathers, among them 24 drug users, eight former users and two non-users at the time of co-parenting. 14 women were in relationships and co-parenting with partners. The current drug status of the 19 partners compared with the 34 former partners/children's fathers drug status while in the relationship with the women somewhat challenges Rosenbaum's thesis of 'narrowing options' with regard to partner choice after a career in drug use. Perhaps her thesis and Klee's assertions with regard to limited partner choice do not hold in the long-term in the Irish situation as women's drug status changes.

In terms of accommodation 17 women resided in local authority housing, five of whom were living with their families of origin while a sixth woman lived with her partner's family. Eleven women were living in local authority housing rented under their own name. Only one woman was an owner-occupier. The remaining eight women were currently out of home. Three women were sleeping rough, three were living in Bed & Breakfast accommodation (B&B), one was living in sheltered accommodation and one was living temporarily with her sister in her private rented accommodation. Almost all the women had experienced homelessness or being out of home at some stage during their lives.[25]

At the time of interviewing the 26 women, four women, three of whom were drug free and the other on methadone maintenance, were in full-time employment, while three women, two methadone maintained and one drug free, were engaged in part-time work on community employment schemes. A further 10 women, all on methadone maintenance, were engaged in education and training in Special Community Employment Projects while another woman was attending a third level institution and doing a full-time degree course. Eight women, three of whom were methadone maintained and five of whom were currently using drugs, were unemployed. Various employment careers were reported, several women working throughout long periods of their drug using careers. Many engaged in cleaning work, street trading and other jobs at various moments.

Motherhood

Of the 205 participants, 193 women were mothers and collectively they had a total of 442 children ranging in age from infancy to independence between them, some living with them and some in the care of others.[26] In addition four women, two interviewees, one group member and one contact were caring for other people's children, involving a further seven children. Twelve women met in the course of participant observation had no children currently. However three were pregnant at the time of meetings and six others anticipated that they would have children in the future.[27] Three women were grandmothers of a total of eight grandchildren.

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[25] In the course of fieldwork among the larger group of 205 women, the numbers currently experiencing homelessness were higher than in the subset of women who were interviewed. This may be explained by the higher levels of current use among women accessed on the street. Those interviewed were theoretically sampled to include women using, methadone maintained and drug free. However many had experienced homelessness over a lifetime and career in drug use. This echoes Cox and Lawless' 1999 finding that in a group of 190 clients who were interviewed at the Contact Centre of the Merchants' Quay Project in Dublin during a week in February 1999, 63% of respondents were currently homeless. Among them only 7% reported that they had never experienced homelessness.

[26] Fifty-one women had one child; 72 women had two children; 46 women had three; 15 women had four; five women had five children and four women had six. The average age of the 193 mothers was 30.52 years.

[27] Almost all expressed the desire to become a mother at some stage of their lives and anticipated that they will have children. Some women suggested that they could not possibly have children at present because of their drug use, their homeless situation or their work in prostitution. Others stated that they would contemplate pregnancy at some stage in the future when they have become drug free and *'got my head together'* was the most common refrain. However three women, aged 19, 23 and 22 years respectively were in the process of 'becoming' mothers and were pregnant for the first time. I met all of the women again after the end of the fieldwork period with their babies. Two women wanted children but suspected that they had fertility problems and believed at this stage in their lives, at aged 28 and 33, that they were unlikely to become mothers. Another women, aged 38, said that she would have welcomed the opportunity to be a mother. However she was HIV positive and HCV positive and as a lesbian woman would only consider insemination by donor. She believed that she would not be approved as a potential mother, a candidate for donor insemination.

Whereas several contacts were currently childless, all 26 women interviewed were mothers and between them had a total of 64 living children.[28] Two women were caring for a total of four 'foster' children bringing the total number of children born to or cared for by women interviewed to sixty-eight.[29] Family size ranged from one child to six children. [30] Average family size was 2.46 and with the four foster children included it increased to 2.61. Childcare arrangements varied but in general the women contacts' experiences in terms of childcare, loss of custody on either a voluntary or non-voluntary basis by family or state reflect the experiences of the 70 women interviewees.[31]

The average age of children was approximately 10.08 years although again there is a wide range; the youngest child was six months while the oldest, now mothers themselves, were 24 years of age.[32] At first interview 15 children were under four years, four of whom were less than one year and 11 were between one and four years. Twenty-eight children were aged between four and 12 years, 15 between four and eight years while 13 were between nine and 12 years. This is significant as internationally children of drug using parents of primary school age represent an often under-researched age group when compared with their infant or adolescent counterparts (Hogan & Higgins, 2001). Sixteen children were aged between 13 and 17 years and nine were 18 years and more.

Drug Use

The 205 women encountered reported varying drug use and drug treatment histories. More than half (53.65%) or 110 women were methadone maintained at first meeting, 21 women (a little over 10%) were drug free and 74 women (a little over 36%) were currently using street drugs. However although the majority of women group members were in contact with treatment agencies and a small minority are drug free, a large number of women contacts were either currently using, in and out of treatment, or on treatment currently.

Of the 26 women interviewed, 16 were on methadone maintenance, five were using street drugs and five were drug free and described themselves as 'in recovery'. Two women were drug free at first interview, using at the second and reinstated on methadone programmes at the third. Accounts of initiation into drug use and the drug careers of the women are described and

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[28] Six women were the mothers of one child; nine women had two children each; seven had three children; two had four while one woman was the mother of five children and one the mother of six .

[29] One of the women was caring, alongside her own two children, for her deceased sister's two children. Another was caring for the two children of her male partner. These children's birth mothers were also drug users.

[30] Average family size was 2.46 and with the four foster children included it increases to 2.61.

[31] Whereas precise figures can be offered for the women who participated in interviews and focus groups, it was more difficult to determine the living arrangements of the children of all the women met in the course of the fieldwork. However, Appendix III details what is known about the 205 women, their age, the drug status and the numbers of their children.

[32] There were 39 boys, their age ranging from 6 months to nineteen years and 39 girls ranging from one to twenty four years.

discussed in the body of the thesis while their drug histories and careers were reviewed particularly in the context of their parenting careers.[33]

Of the 26 women, only three never injected drugs. Although it may not necessarily be the favoured route of administration, 23 women injected heroin and other drugs at some stage. Several women mentioned that they had only injected on small number of occasions.[34] [35]

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[33] Sixteen women were in receipt of methadone during the course of the study. The age range of this group of 16 women was 23 – 44 years. Two women described themselves as currently undergoing a detoxification from their methadone maintenance programmes. Several others anticipated detoxification soon. Two women described themselves at first interview as drug free, used again and were reinstated on their methadone maintenance programmes by later interviews. Twelve described themselves as *'stable'* on their methadone programme, while four described themselves as *'less stable'*, *'unstable'* at points, and using street drugs, alcohol and/or benzodiazepines problematically. Those describing themselves as less stable maintained that they were *'clean'* for opiates but had significant difficulties with either alcohol or benzodiazepines or both. Those who described themselves as stable are *'just sticking to my phy'*. But almost all on methadone or detoxification felt that their stability was impacted upon by involvement in treatment and counselling programmes, having a job, a training course or a programme, a supportive partner, family and community, and no current crises. They felt that sometimes things occurred which threatened their stability somewhat, at least even temporarily. Of the four describing themselves as unstable, there was a diverse picture. Sharon was homeless and although her partner had become drug free, he was consuming a lot of alcohol. She too was drinking extremely heavily. Darina and Alison found it extremely difficult to maintain stability as their partners were currently using, one having been unable to access treatment thus far while the other partner had been sanctioned by the clinic and *'thrown off'*. Marina's partner was imprisoned currently. Her support system had recently changed and her relationship with her partner had deteriorated as a result of disputes during visits.
Others, describing themselves as stable, talked about occasional use of drugs for pleasure, their *'Thelma and Louise weekends'* [Liz]. The majority viewed use of hash and grass as non-problematic or recreational use and acknowledged that this use is regular. Several women mentioned their concerns about their use of alcohol and a number had either completely eliminated alcohol use or had reduced it significantly.
Five women were drug free, neither using street drugs nor methadone as a substitution. These women's ages ranged from 30 - 44 years and the length of time drug free varied. One woman was 17 years drug free; another 14 years; while two others were drug free approximately five years, and one is drug free three years. In fact one woman was interviewed the day after she had celebrated five years drug free. Three women used no other substances, including alcohol, and followed a *'fellowship'* programme while the fourth woman had been drug free a lengthy period and while had initially remained alcohol free, she now drinks occasionally. The fifth drug free woman consumed alcohol and said, *'I know I have to watch it'* [Amy].
Five women were currently using street drugs, including opiates and benzodiazepines, their ages ranging from 18 – 29 years. While three women had varied drug use and drug treatment histories, two had not yet encountered the drug treatment system. Sandra, the youngest woman, had never had contact with the drug treatment system to date other than using needle exchange facilities. Avril had recently made an appointment for an assessment in order to be admitted to treatment for the first time. All five also referred to the problematic nature of their alcohol consumption.

[34] Wendy had only injected three times. Darina injected drugs between 16 and 21 years. There followed a lengthy period of not using. After she recommenced use, she smoked heroin. She never injected again.

[35] Most started snorting and smoking heroin, although some described their first use as a *'skin pop of heroin'* and several injected. The majority moved to injecting quite quickly, probably due to the fact that *'everyone was doing it'*. It has been documented that Dublin has had in the past and continues to have a strong injecting culture (Butler, 1991). Some women also suggested that *'it takes less to do more'* when injecting and therefore for financial reasons *'makes more sense'*, echoing the women in an earlier study (Taylor, 1993). Several identified their only route of administration as smoking, while others described smoking as their favoured route. However they often injected drugs also.

> *I smoked for a long long time. I was primarily, I would have to say, I preferred smoking because I could justify ...cause I had a lot of the drugs at the time. Now I had a lot one day and none the fuckin' next day and if I didn't have enough I'd fuckin' skinpop or bang up. But I would say I was primarily a smoker, if that makes sense cause that was my preference. Cause I could justify just fuckin' usin'. And it was when I had plenty. But I did use needles, I did bang up and stuff like that.* [Katherine]

Several women were terrified of injecting and needles and avoided injecting as much as possible.

> *No I smoked. No I injected three times. I didn't like the injecting. I felt it was very sore and like when Paul was puttin' the needle into me arm, he was getting' me vein and then he'd be losing it and there were puncture holes all over me and it was hurting me....* [Wendy]

Sixteen women were Hepatitis C positive, five of whom were also HIV positive. Eight women were HIV negative and HCV negative while two did not know their HIV/HCV status.

Of the 26 women, 22 women had been treated with methadone at some stage of their drug using careers, three of whom were then drug free and three of whom were using. Three women had been on methadone and were now drug free, two for approximately five years and one for three years[36]. The longest continuous treatment with methadone was 19 years while the shortest period reported was six months.

For the purpose of the study, it was crucial to involve women at various ages and at differing stages of their drug-using, drug treatment and parenting careers in order to highlight the diverse nature of experiences and accounts.[37] Several women, now drug free, offered retrospective accounts of parenting while using drugs or in treatment. Women currently involved with the treatment system offered accounts of mothering while using and in treatment. In addition, varied accounts of parenting were also offered by women currently using drugs, three of whom previously had involvement with the treatment system and all of whom had periodically parented while drug free. The women, all drug users, recounted experiences, not unlike some of those identified in a small number of previous studies. Studies often were narrow in their sampling – focusing on the experiences of women currently using street drugs; on women in treatment programmes; women in receipt of methadone; women with children in their care; women in prison; women with children under three years of age. This study in contrast has attempted through theoretical sampling and constant comparison to be as inclusive as possible and to engage women at many different stages of their drug-using careers and parenting involvement.

> *The thing with smoking as well. Jaysus! I always thought people that were on drugs used needles you know. I really didn't know you could smoke gear and that's when I think I started. That's what makes it easier for younger people to get strung out on drugs.* [Helen]

Some abandoned injecting at different stages of their careers. Darina described how she became drug free at 21 years and remained so for a further eight years. When she recommenced drug use she *'smoked the gear'*.

> *I just smoke it. I wouldn't touch a needle now. I don't know. I think it's a second chance in life I got. When people were getting' tested for HIV, I reckon I should have had it. So I said "I'm after getting' a second chance in life" and I swore to God I wouldn't touch a needle again if I did (test negative). So I didn't touch a needle again.*

[36] Andrea had been in receipt of methadone for three years before she *'just stopped like that. I'd had enough'*. Katherine was on methadone for less than a year, having initially entered a programme during her first pregnancy which she later lost. Amy had been on methadone for nine years.

[37] This presented the opportunity to explore these issues from a number of perspectives. Only two interviewees and a minute number of group members or contacts had no involvement ever (yet) with the treatment system. Indeed it is difficult, almost impossible, to find a woman who has been pregnant and is involved in parenting, who is neither currently involved with the treatment system or has never had involvement. However, Avril was waiting to be assessed for treatment and Sandra hoped to access treatment shortly. Several of the women met in fieldwork are relatively new to the scene and have not yet been treated. It is not a linear progression and in fact many have been in and out of the treatment system. One woman, met during fieldwork, said *'We used to be in and out of the prison, the revolving door thing, you know. Now it's in and out of treatment'*.

Appendix V – The 40 Professional Workers Interviewed *

Social Worker, non-statutory drug service (W 01)

Addiction Counsellor, statutory drug service (W 02)

Social Worker/Manager, non-statutory drug service (W 03)

Community Worker/Manager, non-statutory drug service (W 04)

Community Worker, non-statutory drug service (W 05)

Community Worker, non-statutory drug service (W 06)

Nurse, statutory drug service (W 07)

Addiction Counsellor, non-statutory drug service (W 08)

Social Worker, statutory maternity hospital & community care (W 09)

Nurse, statutory drug/HIV outreach service(W 10)

Community Worker, non-statutory drug project (W 11)

Consultant Psychiatrist, statutory drug service (W 12)

Social worker, statutory drug service (W 13)

Refuge Support Worker, statutory service (W 14)

Social Worker, formerly of non-statutory drug project & community care (W 15)

Addiction Counsellor/Manager, statutory drug service (W 16)

Social Worker, non-statutory youth service (W 17)

Addiction Counsellor, non-statutory drug service (W 18)

Addiction Counsellor, non-statutory drug service (W 19)

Social Worker, statutory hospital- based HIV Service (W 20)

Addiction Counsellor, non-statutory drug service (W 21)

Teacher/Manager, non-statutory drug/prison service (W 22)

Social Worker, statutory social work service (W 23)

Nurse, statutory HIV service (W 24)

Child Care Worker, non-statutory drug service (W 25)

Social Worker, statutory community care social work service (W 26)

Refuge Support Worker, statutory service (W 27)

Public Health Medical Consultant, statutory service (W 28)

Consultant Psychiatrist, statutory drug service (W 29)

Consultant Psychiatrist, statutory drug service (W 30)

Social Worker, statutory community care social work service (W 31)

Social Worker, statutory community care social work service (W 32)

Nurse – Midwife, statutory drug service (W 33)

Community Worker, non-statutory drug service (W 34)

Nurse, statutory paediatric HIV medical service (W 35)

Addiction Counsellor, non-statutory drug service (W 36)

Social Worker, statutory community care social work service (W 37)

Community Drug Worker, non-statutory drug service (W 38)

Social Worker, statutory probation service (W 39)

Medical Social Worker, statutory maternity service (W 40)

* This information about professional workers' occupations and experience was accurate at time of interview.

Appendix VI – The Women's Reproductive Histories

Woman	No of pregnancies	Age	Outcome	Using/non-using	Age of Child
Alison	2	18	Daughter	Not using	6
		22	Daughter	Methadone	3
Amy	3	17	Son	Using/Methadone	17
		18	Son	Using/Methadone	16
			Termination	Methadone	----
Andrea	2	17	Son	Not using	14
		23	Son	Using	8
Arlene	8	19	Daughter	Not Using	17
		20	Daughter	Using/Methadone	16
		24	Daughter	Using/Methadone	12
		32	Son cot death in hosp	Using/Methadone	------
		34	Twin Daughter Stillborn Twin Miscarriage	Using/Methadone	------ ------
			Little Known	Using	------
			As above	Using	------
			As above	Using	------
Avril	1	17	Son	Using	8
Brenda	3	18	Miscarriage	Using/stopped	------
		26	Son	Using	13
		33	Daughter Stillborn at 7 months gestation	Using/methadone	------
Darina	3	20	Son	Methadone	16
		27	Son	Not using	9
		33	Son	Using/Methadone	3
Elaine	5	17	Daughter	Using/stopped	11
		20	Son	Using	8
		24	Son	Using	4
		28	Daughter	Using/methadone	7 months
		29	Daughter Stillborn 6/7 months gestation	Using	------
Ellen	2	21	Daughter	Using/stopped	19
		28	Daughter	Not using	12
Emma	3	18	Daughter	Using/stopped	12
		21	Daughter	Using/methadone	9
		25	Son	Using/methadone	5
Ethna	2	26	Son	Not using	10
		29	Son	Not using	7
Frances	4	20	Daughter	Using	24
		22	Daughter	Using	22
		24	Daughter	Using	20
		27	Daughter	Using	17
Helen	1	22	Son	Methadone	8 months
Janet	2	15	Son	Not using	8
		19	Son	Using	4
Jenny	1	21	Daughter	Methadone	1.5
Katherine	4	24	Miscarriage Miscarriage	Using/methadone	------ ------
		26	Daughter	Not using	3.5
		27	Daughter	Not using	2.5
		29	Son	Not using	7 months

Laura	3	20	Daughter	Not using	24
		25	Daughter	Using/methadone	19
		26	Son	Using/methadone	18
Liz	2	23	Daughter	Using	17
		25	Son	Using	15
Maeve	4	18	Son	Using/methadone	3
		19	Son	Methadone	2
		19	Abortion	Methadone	------
		20	Daughter	Methadone	1
Marina	3	18	Son Stillborn Son Stillborn born at 24 weeks gestation	Using	------ ------
		19	Daughter	Not Using	8
		23	Daughter	Using	4
Rachel	5	23	Daughter	Methadone	15
		24	Daughter	Methadone	15
		26	Daughter	Methadone	13
		27	Daughter	Methadone	12
		30	Daughter	Methadone	9
Sandra	1	17	Son	Using	6 months
Sharon	6	20	Son	Not using	19
		21	Daughter	Not using	18
		23	Daughter	Not using	16
		25	Son	Not using	14
		27	Son	Using/methadone	12
		33	Son	Using/methadone	6
Sheila	4	20	Daughter	Not using	8
		21	Miscarriage	Not using	------
		22	Son	Using/methadone	6
		25	Daughter	Methadone	3
Susie	1	22	Daughter	Methadone	18 months
Wendy	1	20	Twin Daughter Twin Daughter	Methadone	3.5 3.5
Total	76				

Appendix VII – The Women's Chidren and Care Arrangements

Woman	Child	Age	Status	Current Living Arrangments	Placement history
Alison	Martina (Girl)	10	Minor	Partners' child Alison doing all the parenting	For two and a half years. Previously with birth mother
	Sharon (Girl)	9	Minor	Partner's child Alison doing all the parenting	As above
	Lisa (Girl)	6	Minor	With grandmother	Since 2 years of age
	Laurie (Girl)	2	Minor	With mother and father	Always with mother
Amy	John (Boy)	17	Minor	With mother	Always with mother
	Joseph (Boy)	16	Minor	With mother	Always with mother
	Tony (Boy)	14 (foster)	Minor	With (foster) mother	Since sister's death – 1995
	Helena (Girl)	12 (foster)	Minor	With (foster) mother	Since sister's death – 1995
Andrea	Conor (Boy)	14	Minor	With mother	With grandmother and aunt for six months 1993 – 1994
	Killian (Boy)	8	Minor	With mother	With grandmother and aunt for six months 1993 – 1994
Arlene	Lorraine (Girl)	17	Minor	Foster care	Since 3 years of age
	Naomi (Girl)	15	Minor	Foster care	Since 2 years of age
	Sandra (Girl)	12	Minor	With father's family	Since 2 years of age
Avril	Shane (Boy)	8	Minor	With grandmother	Almost since birth
Brenda	Harry (Boy)	13	Minor	With mother and father	Always with mother and father
Darina	Brian (Boy)	16	Minor	With grandfather	Had always lived with grandmother until her death two years before
	Frank (Boy)	9	Minor	With mother and father	Always with mother and father
	Andrew (Boy)	3	Minor	With mother and father	Always with mother and father
Elaine	Ashling (Girl)	11	Minor	Foster care	6 years
	Alan (Boy)	8	Minor	Foster care	6 years
	Paul (Boy)	4	Minor	Foster care	3 years
	Aoife (Girl)	7 months	Minor	Foster care	Just prior to 1st interview – 7 months old
Ellen	Sally (Girl)	19	Adult	With mother	Always with mother
	Rachel (Girl)	12	Minor	With mother	Always with mother
Emma	Catherine (Girl)	12	Minor	With grandmother	With grandmother since birth
	Ruth (Girl)	9	Minor	With grandmother	Since 3 years of age
	Greg (Boy)	4	Minor	With mother	Always with mother

Ethna	Ciaran (Boy)	10	Minor	Foster care	With foster family (not with sibling) four weeks at time of interview
	Sean (Boy)	7	Minor	Foster care	With foster family (not with sibling) four weeks at time of interview
Frances	Jean (Girl)	24	Adult	Living with parents (with her partner and 2 children)	Always with mother and father
	Valerie (Girl)	22	Adult	Independent (Living with child)	As above
	Elizabeth (Girl)	20	Adult	Independent	As above
	Sandra (Girl)	17	Minor	With mother and father	Always with mother and father
Helen	Declan (Boy)	8 months	Minor	With mother/father	Always with mother and father
Janet	Tomas (Boy)	8	Minor	With grandmother	Always with grandmother
	Colm (Boy)	4	Minor	With mother	Always with mother
Jenny	Jessie (Girl)	1	Minor	With mother	Always with mother
Katherine	Lynn (Girl)	3	Minor	With mother	Always with mother
	Margaret (Girl)	2	Minor	With mother	Always with mother
	Rory (Boy)	7 months	Minor	With mother	Always with mother
Laura	Karina (Girl)	24	Adult	Independent	Separated from early childhood years
	Melanie (Girl)	19	Adult	Resident with father in family home	At 15 years
	Jack (Boy)	18	Adult	Resident with father in family home	14 years
Liz	Darina (Girl)	17	Minor	With mother	Separated from 1988 – 98
	Marty (Boy)	15	Minor)	With mother	Separated from 1988 – 1998
Maeve	Gerard (Boy)	4	Minor	Sister	With sister and brother in law
	Paul (Boy)	3	Minor	With mother	Always with mother
	Lorraine (Girl)	1	Minor	With mother	Always with mother
Marina	Angela (Girl)	8	Minor	With mother	Always with mother and father
	Claire (Girl)	4	Minor	With mother	Always with mother and father
Rachel	Linda (Girl)	15	Minor	With grandmother	Past 4 years due to mother's ill health
	Joanne (Girl)	15	Minor	With grandmother	Past 4 years
	Esther (Girl)	13	Minor	With aunt	Since babyhood
	Anna (Girl)	12	Minor	With grandmother	With family friend
	Eleanor (Girl)	9	Minor	Since birth for 3 years with brother and sister in law With grandmother	Past 4 years
Sandra	Dean (Boy)	6 months	Minor	With mother	Always with mother

Sharon	Keith (Boy)	19	Adult	Independent (a father now) – his partner lives in the home of her family of origin	In foster care 1990 – 1991
	Rebecca (Girl)	18	Adult	Independent (living with child)	In foster care 1990 – 1991
	Gemma (Girl)	16	Minor	Foster care	In foster care 1990 – 1991 In foster care 1999 – ongoing
	Eddie (Boy)	14	Minor	Foster care	In foster care 1990 – 1991 In foster care 1999 – ongoing
	Gerard (Boy)	12	Minor	Foster care	In foster care 1990 – 1991 In foster care 1999 – ongoing
	James (Boy)	6	Minor	Foster care	In foster care 1999 – ongoing
Sheila	Crona (Girl)	8	Minor	Sister	With sister and brother in law – First time in care of others
	Oisin (Boy)	6	Minor	Sister	With sister and brother in law
	Grainne (Girl)	3	Minor	Sister	With sister and brother in law
Susie	Cliona (Girl)	1	Minor	With mother	Always with mother
Wendy	Cathy (Girl)	3	Minor	With mother	Always with mother
	Caroline (Girl)	3	Minor	With mother	Always with mother
Total	29 boys 39 girls 68 children	Average ages – 10.08 years	59 minor children/9 adult children	27 minor children living with their birth mothers currently 32 children are living with others	Of the 68 children 27 have always lived with their birth mothers (to date) while 41 have experienced changes in primary carer/separation from mother.

* All names have been changed in order to protect anonymity.

Appendix VIII – Parenting & Drug-Using Status

Parenting while using	Parenting while on methadone	Parenting while drug free
Alison	Alison	Alison
Amy	Amy	Amy
Andrea	Andrea	Andrea
Arlene	Arlene	Arlene
Avril	----	Avril
Brenda	Brenda	Brenda
Darina	Darina	Darina
Elaine	Elaine	Elaine
Ellen	----	Ellen
Emma	Emma	Emma
Ethna	Ethna	Ethna
Frances	----	Frances
----	Helen	----
Janet	Janet	Janet
----	Jenny	----
----	----	Katherine
Laura	Laura	Laura
Liz	Liz	Liz
Maeve	Maeve	Maeve
Marina	Marina	Marina
----	Rachel	----
Sandra	----	----
Sharon	Sharon	Sharon
Sheila	Sheila	Sheila
----	Susie	----
Wendy	Wendy	Wendy
21	21	21

Appendix IX – Motherhood Status

Motherhood role performed	Motherhood interrupted on some children	Motherhood interrupted on all	Motherhood restored/ retrieved	Current status
Alison (2 children)	Alison (1 child)			Motherhood Interrupted
Amy (2 children)				Motherhood preserved
Andrea (2 children)		Andrea (2 children)	Andrea	Motherhood retrieved
Arlene (3 children)		Arlene (3 children)		Motherhood Interrupted
Avril (1 child)		Avril (1 child)		Motherhood Interrupted
Brenda (1 child)				Motherhood preserved
Darina (3 children)	Darina (1 child)			Motherhood Interrupted
Elaine (4 children)		Elaine (4 children)		Motherhood Interrupted
Ellen (2 children)				Motherhood preserved
Emma (3 children)	Emma (2 children)			Motherhood Interrupted.
Ethna (2 children)		Ethna, (2 children)		Motherhood Interrupted
Frances (4 children)				Motherhood preserved
Helen (1 child)				Motherhood preserved
Janet (2 children)	Janet (1 child)			Motherhood Interrupted.
Jenny (1 child)				Motherhood preserved
Katherine (3 children)				Motherhood preserved
Laura (3 children)		Laura (3 children)		Motherhood Interrupted
Liz (2 children)		Liz (2 children)	Liz	Motherhood retrieved
Maeve (3 children)	Maeve (1 child)			Motherhood Interrupted
Marina (2 children)				Motherhood preserved
Rachel (5 children)		Rachel (5 children)		Motherhood Interrupted
Sandra (1 children)				Motherhood preserved
Sharon (6 children)		Sharon (6 children) (2 occasions)	Sharon (1 occasion)	Motherhood Interrupted
Sheila (3 children)		Sheila (3 children)		Motherhood Interrupted
Susie (1 child)				Motherhood preserved
Wendy (2 children)				Motherhood preserved

Appendix X

Trajectory of Drug - Involved Motherhood

(Member Checking Interviews & Groups)

