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Chapter 5

RETHINKING HARM REDUCTION AND PREGNANCY: A STUDY OF WOMEN'S EXPECTATIONS AND EXPERIENCES OF SPECIALIST MATERNITY CARE AND OPIATE SUBSTITUTION TREATMENT

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ABSTRACT

While maternity services that specialize in providing opiate substitution treatment to pregnant women are commonly considered a significant harm reduction initiative, a number of women do not access these services, or disengage from them as their pregnancies progress. This chapter offers insight into why this might be the case through a comparative examination of pregnant women's expectations of drug treatment and the structure and administration of specialist maternity care. Drawing on interviews with 21 young pregnant women and new mothers who were current or former clients of a specialist maternity clinic located Melbourne, Australia, the chapter demonstrates that pregnant women are often highly motivated to access drug treatment for a variety of reasons, but that their expectations are sometimes confounded by the care they receive. The aim of this chapter is to identify some of the limitations of existing drug treatment supports for pregnant women and to discuss how efforts to meet the varied and sometimes conflicting needs of this group might be based on a broader understanding of harm reduction.

Keywords: maternity services, pregnancy, opiate substitution treatment (OST), service access, child welfare, pharmacotherapy, methadone, Australia, women

INTRODUCTION

According to both sociological and clinical studies, many women seek information and support to address their illicit drug use during pregnancy (Bailey, Hill, Hawkins, Catalano, & Abbott, 2008; Daley, Argeriou, & McCarty, 1998; Lundgren, Schilling, Fitzgerald, Davis, & Amodeo, 2003; Simpson & McNulty, 2008). Most appear to do so based on a combination of concern for the health of their unborn child and corresponding concerns about neonatal abstinence syndrome, as well as fear of child protection intervention (Boyd, 1999; Klee, Jackson, & Lewis, 2002; Murphy & Rosenbaum, 1999; Taylor, 1993). As Avril Taylor observed in her now classic study of women injecting drug users:

> Most women were aware of the risks associated with continued drug use, and almost without exception they attempted to stop their drug taking out of fear of the harm they would do to their child, and out of fear that the child, when born, would be removed from their care. (1993, p. 104)

While some pregnant women seem to aspire to become drug-free before the birth of their child (Bailey et al., 2008; Klee et al., 2002), others aim for more modest goals, such as modifying or reducing their drug use (Banwell & Bammer, 2006; Richter & Bammer, 2000). In both cases, a desire to do what is best for the baby appears to be women's main motivation. These findings reinforce a common observation that there is little in the way that women who use illicit drugs conceptualize the determinants of fetal health, the meaning of motherhood, and the value of children that differs from their non-drug-using counterparts (Baker & Carson, 1999; Chandler et al., 2013; Klee, Jackson, & Lewis, 2002; Murphy & Rosenbaum, 1999; Radcliffe, 2009; Rhodes, Bernays, & Houmoller, 2010). They share a normative view that "good mothers" do not put their own needs before those of their children by drinking alcohol, smoking cigarettes, or taking non-prescribed drugs during pregnancy (Bell, McNaughton, & Salmon, 2009), as is evident in the profound feelings of guilt and shame experienced by some (Klee et al., 2002).

Studies suggest that some pregnant women—often those having their first child—also try to address their drug use because they view pregnancy as an opportunity to make broader changes in their lives (Boyd, 1999; Murphy & Rosenbaum, 1999). It is not uncommon for women to anticipate that becoming a mother has the potential to lead to improvements in their health and wellbeing, as well as in the quality of their relationships with others; these changes, in turn, are seen as a way to contribute to realizing a number of longer-term objectives, such as gaining meaningful employment and finding stable housing (Banwell, 2003; Copeland, 1998). Some have interpreted these findings in relation to the stigma associated with illicit drug use—particularly for women, whose failure to conform to normative gender expectations makes them "doubly-deviant" (Rosenbaum, 1981)—and to the desire to restore a positive self-identity (Bessant, 2003; Brudenell, 1997; King, Ross, Bruno, & Erickson, 2009). In other words, for many women who are illicit drug users, especially those who have also experienced poverty, homelessness, and other forms of marginalization, having a child can be an occasion to claim a socially acceptable identity (Murphy & Rosenbaum, 1999; Olsen, Banwell, Dance, & Maher, 2012; Radcliffe, 2011).

At the same time, the barriers to care for pregnant women who use illicit drugs are widely acknowledged in the treatment literature (see for example Jessup, Humphreys, Brindis, &

Lee, 2003; Poole & Issac, 2001; Sword, 1999). Although many women's first contact with drug treatment services is during pregnancy (Corse & Smith, 1998) and often occurs on a voluntary basis (Ekendahl, 2007), a number of women do not access drug treatment until later in their pregnancies and/or subsequently disengage from these services as their pregnancies progress (Greenfield et al., 2007; Haller, Knisely, Elswick, Dawson, & Schnoll, 1997). By far the most commonly cited reason women avoid drug treatment services is anxiety about the possibility of child protection intervention (Greaves & Poole, 2008; Jessup et al., 2003; Powis, Gossop, Bury, Payne, & Griffiths, 2000; Roberts & Nuru-Jeter, 2010), and a corresponding fear of being judged (Jessup et al., 2003; Klee et al., 2002; Murphy & Rosenbaum, 1999; Simmat-Durand, 2007).[1] Similar concerns have been found to prevent many women who use illicit drugs from accessing prenatal care and/or disclosing their drug use to prenatal care providers (Flavin & Paltrow, 2010; Kaltenbach, Berghella, & Finnegan, 1998; Roberts & Nuru-Jeter, 2010; Wechsberg, Luseno, & Ellerson, 2008). It is worth noting that preoccupation with drug use has been found to have little influence on pregnant women's willingness to access either prenatal care or drug treatment services (Tobin, 2005).

These barriers to care are arguably an outcome of the kind and degree of surveillance and monitoring which women who use illicit drugs are routinely subject to (Ettore, 2007; Mulia, 2002; Paltrow, 1999; Toscano, 2005; Young, 1994). Most current health and welfare systems place heavy emphasis on protecting the welfare of children—both born and unborn (Jos, Perlmutter, & Marshall, 2003; Lupton, 2012). This emphasis contributes to the widespread stigmatization and judgment of pregnant women who use illicit drugs (Boyd 1999; Ettore 1992; Murphy & Rosenbaum, 1999; Radcliffe, 2009; Rosenbaum 1981; Taylor 1993), which invariably also influences medical, health, and welfare professionals' attitudes and actions (Benoit et al., 2014). Women who use illicit drugs during pregnancy are often therefore caught in a double-bind: while demonstrating a willingness to engage in treatment is often a basic prerequisite to maintain custody of their children (Radcliffe, 2009, 2011), doing so also places them under the often punitive control of health and welfare professionals (Young, 1994).

There is growing consensus that better engaging and retaining pregnant women depends on addressing this issue and improving their experiences of both drug treatment and prenatal care (Campbell & Ettorre, 2011; Greenfield et al., 2007; Simpson & McNulty, 2008). Several studies highlight, in particular, the necessity of recognizing and accommodating the realities of pregnant women's complex life circumstances (Greaves & Poole, 2008; Najavits, 2002). A number of others have called more generally for health and welfare professionals to provide more non-judgmental forms of support (Boyd & Marcellus, 2007; Sword, 1999). What is vitally important, from the perspective of treatment-focused studies, is to avoid missing pregnancy as a "window of opportunity" to help women better manage their drug use and mitigate some of the significant financial, social, physical, and psychological harms that they commonly experience (Boyd & Marcellus, 2007; Greaves & Poole, 2007; Klee et al., 2002). Many claim that providing more "integrated" or "specialized" services for pregnant women based on the principles of harm reduction will help meet this goal (Greaves & Poole, 2007; Hall & van Teijlingen, 2006; Hepburn, 1997; Milligan et al., 2010, 2011a; Mitchell, Hall,

[1] Other significant barriers include homelessness, poverty and transportation issues (Moreno, El-Bassel, Gilbert, & Wada, 2002; Wenzel et al., 2009) and ongoing parenting responsibilities and the need for childcare (McMahon et al., 2002; Mulia, 2002).

Campbell, & van Teijlingen, 2003; Morris, Seibold, & Webber, 2012; Niccols et al., 2012; Rosenbaum & Irwin, 2000).

The Multiple and Conflicting Aims of Specialist Maternity Care

Specialist services and maternity care clinics for pregnant women with substance use concerns were established in the major urban centers of several countries, including Canada and Australia, beginning in the late 1980s. The defining feature of these services is the provision of prenatal care and drug treatment "through a single point of access" (Leslie, 2007, p. 240). These services are typically provided via multidisciplinary teams that include psychologists, social workers, nurses and/or midwives, and obstetricians. Depending on their location and degree of collaboration with community-based partners, and their distinct philosophies of care, additional supports may include mental health counselling, housing information and referrals, childbirth education, nutrition advice, and parenting programs (Milligan et al., 2010). In most countries, such as the U.K., Australia, and Finland, specialist maternity care services are located in hospitals, but they can also be community-based, which is the case in Canada.

A major impetus for the establishment of this model of integrated care was mounting evidence demonstrating the risks associated with substance-dependence during pregnancy, particularly opiate-dependence, and the barriers to prenatal care for this group (see Hepburn, 1997; Milligan et al., 2011; Morris, Seibold, & Webber, 2012). Correspondingly, a frequently cited rationale for specialist maternity care is to encourage attendance by providing care in a way that is non-judgmental and supportive and that addresses "the complex problems of chemically-dependent women" (Morris et al., 2012, p. 164). The establishment of specialist maternity services also developed in close conjunction with growing clinical support for the provision of methadone, and later, buprenorphine, for the management of opiate dependence in pregnancy (see Kaltenbach et al., 1998; Walker & Walker, 2003; Ward et al., 1998). Proponents describe this particular treatment modality as instrumental to improving access and retention, given that "insistence on abstinence may deter women from engaging in care" (Walker & Walker, 2003, p. 225).

Specialist maternity services are frequently claimed to represent a harm reduction approach to the management of substance dependence during pregnancy. This claim is often made regarding hospital-based clinics on the basis that their focus is not on preventing pregnant women's use of substances but rather on encouraging "drug stability," usually through the provision of opiate substitution therapy (OST) (Morris et al., 2012). Community-based clinics appear to adopt a broader definition of harm reduction that encompasses other supports, such as housing information, known to mitigate some of the harms associated with women's substance use, as well as "supporting any level of change that women feel able to make in their substance use" (Greaves & Poole, 2007, p. 222). In both cases, harm reduction is considered a guiding principle integral to increasing attendance in antenatal care and improving outcomes for both mothers and babies (BC Centre for Excellence in Women's Health, 2010; Greaves & Poole, 2007; Morris et al., 2012).

The existence of specialist services also hinges to a significant extent on the medical norms that currently govern prenatal care, which direct significant clinical resources and attention toward the surveillance and regulation of fetal health and development, especially in pregnancies considered high-risk (Ettorre & Kingdon, 2010; Lupton, 2012). For example, among the most frequently cited benefits of specialist maternity clinics—and the OST provided through them—is that they help to create a "stable environment" for the developing fetus and improve neonatal outcomes (see NSW Health, 2006, 35-36; Morris et al., 2012; Tobin, 2005; Women's Alcohol and Drug Service (WADS), 2003). Moreover, the different OST prescribing regimes in specialist maternity services are often based on assessments of what is considered to be most conducive to positive fetal outcomes, namely reducing the risk of neonatal abstinence syndrome (NAS) while also reducing the risk of maternal relapse, which is associated with increased risk of miscarriage, stillbirth, and premature labour (Walker & Walker, 2003).

Adding another layer of complexity, many of the professionals who work in specialist maternity services have "mandated qualifications," that is, they are legally required to report any suspicion that a client's child is at risk of harm or neglect (Jos et al., 2003). Although in many countries, such as Canada and the U.K., mandatory reporting requirements do not extend to the unborn, the staff of specialist maternity services often work in close consultation with child protective services and may follow specific protocols outlining how and under what circumstances they should notify child protective services (see, for example, Department of Human Services, 2002). Correspondingly, most specialist maternity clinics adopt certain "key risk indicators" used to assess whether there is a risk of harm or neglect to a client's fetus, newborn, or any older children. It is standard practice, in turn, for staff to share information through formal case conferences and in everyday conversations, about the extent to which clients exhibit any of these indicators (Radcliffe, 2009).

In this sense, specialist maternity clinics and services can be said to have multiple and, in some ways, conflicting, objectives. While they aim to better retain and engage pregnant women in drug treatment and maternity care by providing non-judgmental support and adopting harm reduction principles, they invariably prioritize encouraging drug stability, improving birth outcomes, and helping to ensure that the children of women who use drugs are not at risk of harm or neglect. Insofar as their primary orientation is biomedical, services located in hospitals are particularly likely to prioritize the latter (Leppo & Perälä, 2009). However, service providers in community-based settings have also been found to focus on individual drug-taking behaviour as a determinant of health (Benoit et al., 2014). Regardless of location, in other words, specialist maternity clinics tend to be more hierarchical and normative in comparison with other harm reduction programs and services due to a focus on fetal health and the rights of the child (Benoit et al., 2014; Leppo & Perälä, 2009).

Qualitative studies suggest that these conflicting objectives are problematic for some of the women who access specialist maternity care. Studies have found, for example, that clients often desire to be treated like "normal" expectant mothers, but instead perceive that staff regard them as "people who needed to be regularly assessed and warned about the harm that could, and perhaps would, occur to the fetus" (Morris et al., 2012, p. 167). Others have noted women's frustration with the lack of transparency and inconsistencies in the way child welfare policies related to apprehension are interpreted and implemented in these settings (Radcliffe, 2011). This evidence suggests that women often experience a disconnect between their own priorities and those of their specialist caregivers, which might help to explain why

some remain reluctant to access specialist maternity clinics or attend less frequently as their pregnancies progress (Jessup et al., 2003; Morris et al., 2012; Tobin, 2005).[2]

This chapter attempts to provide further insight into the extent to which specialist maternity care services meet women's needs by summarizing key findings of in-depth interviews with young women who had a history of injecting drug use. While the focus of most research on this topic is on retention and substance use outcomes (see Milligan et al., 2010, 2011b), the following explores the contextual factors that both motivate pregnant women to access specialist maternity care and render problematic certain aspects of the care they receive. I draw on these insights to discuss ways in which specialist maternity care services might better engage and support women during pregnancy, thus mitigating some of the harms that they commonly experience.

METHODS

This chapter draws on the findings of semi-structured, in-depth interviews with 21 young women who were pregnant and/or mothers and had a significant history of injecting drug use.[3] The data were collected over two years, from 2004 to 2005 in rural and urban areas of Victoria, Australia. The majority of participants were recruited through the Women's Alcohol and Drug Service (WADS)—formerly known as the Chemical Dependency Unit, or CDU—located at the Royal Women's Hospital in Melbourne. Each interview lasted between one and three hours, and usually opened with an invitation for participants to tell their stories. This then led to discussion that would help elicit an "induced and accompanied self analysis" on the part of research participants (Bourdieu, 1999, p. 613), including their own subjective interpretations of key events or "critical moments" in their lives (Thomson et al., 2002).

At the time the interviews were conducted, I was a young mother myself, and my baby would frequently accompany me to interviews. This point of contact and commonality was helpful in creating trust with the women I interviewed, as was my having undertaken a short placement at the clinic in order to learn more about its daily operations and to become a familiar face to potential research participants.[4] Interviews were one-off and took place off-site—often at participants' homes, or in public locations such as local parks. I was aware that other interviews for various studies had been conducted at the clinic, and wanted to avoid this approach as the perceived power imbalance could have the potential to lead women to feel that they were obliged or expected to participate. For this study, which received ethics approval from the University of Melbourne Human Research Ethic Committee, the

[2] There is also conflicting evidence about the effectiveness of specialist maternity care in comparison with mainstream obstetric and/or drug treatment services. While studies demonstrate that this form of care is more likely to achieve positive birth outcomes for women with substance use issues (Howell, Heiser, & Harrington, 1999; Lejeune, Simmat-Durand, Gourarier, & Aubisson, 2006; Morris, Seibold, & Webber, 2012), others suggest more ambiguous results vis-à-vis reductions in substance use (Niccols et al., 2012), and the likelihood of women maintaining custody of their children (Lean, Pritchard, & Woodward, 2013).

[3] The majority of women interviewed for this study identified themselves as in having injected drugs for substantial period of time—at least one year in most cases. Only one woman I spoke to was a recent "initiate" to injecting drug use.

[4] The recruitment strategy used for this study involved a combination of advertisements placed in and around the WADS clinic, snowball sampling and third-party recruitment by the WADS staff, who either passed on my contact details to women interested in participating in the study, or gained permission from potential participants for me to contact them.

participants all gave informed consent, and I have changed their names to protect their anonymity.

The young pregnant women who participated in the study were between the ages of 18-27 years old, and all but three had injected drugs within the last 12 months.[5] The majority had used heroin primarily, but some also had experience with injecting methamphetamines and prescribed opiates. Seven women were pregnant with their first baby, six were pregnant with their second child, and three were new mothers of young babies (aged six months or younger). During the course of my research, I also interviewed five additional women, each of whom had one child aged six months to two years.[6] The majority of research participants described themselves as attempting to disengage from injecting drug use at the time of our interview; this was either stated outright or implied, through discussions of being on or going on buprenorphine, naltrexone, or methadone.[7] This chapter focuses on the accounts of women who were either pregnant or the mothers of a first baby aged six months or younger. Each of these women had accessed the support of the WADS clinic during pregnancy and nearly all had subsequently commenced OST.

At the time of this study, the WADS clinic provided, via a multidisciplinary team, specialist prenatal care and support for substance dependent women whose pregnancies were identified as "high risk" (Tobin, 2005).[8] The standard treatment at the clinic for opiate dependence was to admit women as in-patients and stabilize them on methadone maintenance therapy (MMT) over five days, then monitor and adjust their dose throughout pregnancy to avoid maternal withdrawal.[9] A typical prenatal appointment at WADS (the standard number of which were higher than in mainstream care)[10] would involve meeting with a staff psychologist and/or social worker, who primarily offered drug and alcohol counselling, and then with a midwife and/or obstetrician, who provided prenatal care and psychosocial support. In practice, the roles often overlapped. For example, the clinic's obstetricians were also OST prescribers and would often assess women's "drug stability"—sometimes via urinalysis—in the course of undertaking otherwise standard prenatal examinations.

Women who received MMT through WADS would normally remain in-patients at the Royal Women's Hospital for up to seven days after giving birth, so that their babies could be

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[5] I did not ask participants to describe their ethnic backgrounds, but information that they provided during the course of interviews suggested that all but one had been born in Australia and that most were of Anglo-European descent.

[6] These latter interviews do not form part of the data explored in this chapter, which focuses on women who were either pregnant or mothers of a baby aged six months or younger.

[7] Women who implied that they occasionally "lapse," but nonetheless identified themselves as maturing out, fall into this category.

[8] Women who suffer from "psycho-social problems," including homelessness, mental illness, previous child protection involvement, and abuse, and/or are polydrug users or whose substance use is "unstable" (e.g., women who inject drugs) fell into this category. Women assessed as "low risk" (e.g., women stable on MMT) were typically referred to mainstream prenatal care services at the hospital. This was in part the outcome of the clinic taking on a more active role providing statewide training, education, information, and advice on issues around pregnancy and substance use, and their need thus, to reduce client caseloads (Tobin, 2005).

[9] According to the clinic's guidelines, this form of pharmaco-therapeutic management of addiction in pregnancy is based on the principles of harm reduction, insofar as it: prevents withdrawal symptoms, promotes psycho-social and lifestyle stability, can reduce drug-related crime, decreases the risk of contracting blood-borne viruses, creates a stable environment for fetal growth and survival, results in less premature births, and encourages regular attendance in antenatal care and counselling (WADS, 2003).

[10] This appointment schedule was established based on the understanding that WADS clients need more frequent prenatal care "so that both the physical and psycho-social aspects of substance use can be addressed" (Tobin, 2005, p. 60).

observed for signs of neonatal abstinence syndrome. Those diagnosed with NAS were placed in the hospital's Special Care Nursery to be stabilized on morphine (the Special Care Nursery is not exclusively for children with NAS or for those born to women being seen through WADS; rather, it serves the entire hospital, providing treatment for infants that are premature or otherwise require special care). It was typically during this point in time that any notifications to the Department of Human Services (DHS), the state agency in Victoria responsible for child protective services, would be made. Among the "key risk indicators" considered in these circumstances were late presentation for antenatal care and/or frequent non-attendance, polydrug use, ongoing drug and alcohol use with severe mental illness, and lack of stable housing (New South Wales Department of Health, 2008, p. 11).[11] A child protection notification would likely be made, for example, if a woman was suspected to have regularly "topped up" her methadone dose based on the results of her urine drug screens, especially if her baby demonstrated relatively severe symptoms of NAS and if she attended the clinic infrequently or late in her pregnancy.

The women in this study offered complex and nuanced descriptions of their expectations and experiences of this service. Themes that emerged in the interviews were identified and analyzed using a coding scheme developed in the course of data collection.[12] The analysis was attentive to the fact that the pregnant women and new mothers who volunteered to participate in this study were likely to represent a relatively motivated population of WADS clients,[13] and that the stigma associated with being perceived as a "junkie mum" would influence how women constructed their accounts (Carr, 2011; Gubrium & Holstein, 2000; Radcliffe, 2011; Rhodes, Bernays, & Houmoller, 2010). The next section uses this analysis to illustrate some of the broader and more immediate contextual factors that influenced these accounts.

Women's Expectations and Experiences of Specialist Maternity Care and OST

Very few of the women in this study talked about their reasons for accessing OST or specialist maternity care per se; rather, most spoke in more generic terms, about why they had decided to access drug treatment, "get help," or seek "information and support." All were powerfully motivated by care and concern for the baby—"wanting to have a healthy baby" and "wanting to keep the baby." As has frequently been observed elsewhere (Klee et al., 2002; Taylor, 1993; Tobin, 2005), many of the women worried about the potential negative

[11] Other "key indicators" included suspected abuse and concerns regarding parenting skills (i.e., being in care of an infant when substantially affected by drugs or alcohol) (see NSW Department of Health, 2006, p.11).

[12] Audio-recordings of the interviews and focus groups were kept in mp3 file format to index time codes and tag key text segments, which were later transcribed. As well as engaging in a thematic analysis (Braun & Clarke, 2006), the data were subject to a series of analytical questions which focused on identifying continuity or discontinuity in women's narratives, where conflicts or tensions arose, and how key themes—such as initiation, addiction, risk, intimate relationships, mothering, guilt/shame, morality etc.—featured within women's narrative accounts.

[13] Several research participants were recruited through the WADS staff. While this method proved to be effective from an ethical perspective—insofar as it helped to ensure that I would not approach anyone in a crisis situation—it likely also skewed the study's findings—insofar as the staff were more likely to pass recruitment material on to clients whom they perceived as "stable" and/or "doing well."

effects of drug use during pregnancy. Some were also all very concerned—sometimes through first-hand experience with a previous child—about the possibility that they might come to the attention of child protection services.

While some were new to formal drug treatment, the majority recounted at least one previous period of drug counselling, supervised detoxification, and/or OST. Several discussed their current pregnancies in relation to these previous, unsuccessful attempts to stop injecting drugs, and described motherhood as an opportunity to "finally" or "really" "do something" about their drug use. Some stated explicitly that they had decided to continue with an unplanned pregnancy because they wanted to take advantage of this "opportunity for change." In other words, many women seemed to take for granted that being pregnant and accessing drug treatment would enable them to stop injecting drugs and that this, in turn, would allow them to "turn their lives around."

Jasmine falls into this category. Five months pregnant with her first child, she explained that she was not sure initially if she wanted to continue with her pregnancy. At the same time, she said she did not want to go through another abortion, and that she felt "deep down" that having a baby was "a chance to stop using drugs."

> I kind of thought that if I have a baby maybe, you know, it will change, 'cause I've seen other friends who've had children and it just... completely changed their lives around.[14]

Jasmine had made previous attempts to go "straight," but she told me that because she was having a baby, this time would be markedly different.

> It was almost like, I guess, the turning point where, you know, I've always wondered why I use and I wanted to find out what triggers me to use.

For some women, the decision to seek treatment during pregnancy coincided with other significant developments, such as entering into a new relationship, that contributed to their perception that having a baby was a "make or break" moment. Twenty-two year-old Sarah, for example, said that her new boyfriend, a non-drug-user and the father of her baby, "wouldn't have a bar of it" if she continued using heroin. She described these circumstances—becoming pregnant and starting a new relationship—almost as a test; if she were ever to quit, it would be at this point in her life:

> It was my option, if I was going to have the kid, there was no chance I was going to use again. So [...] I had to stop then—If I was to use in my pregnancy, I wasn't going to stop, so I had to stop right then and there.

Sarah ultimately considered herself "lucky" that something finally "took precedence" over her drug use:

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[14] Quotations are reproduced verbatim and have not been corrected for grammar. For the sake of brevity, I edited some quotations, as indicated thus [...]. When women use uncommon terminology, I indicate meanings in parentheses.

> I think, lucky I got pregnant. I reckon that saved my life, 'cause I'd still be doing it, I reckon, otherwise.

An important backdrop for these discussions of motherhood as a turning point was the degradation and stigmatization that women had often experienced as women who inject drugs. In conversation, they often portrayed the drug using "lifestyle" as routine and relentless (e.g., having to do "the same thing everyday," "constantly worrying about money and drugs," or "always scamming" to support a habit), and devoid of genuinely intimate relationships with others. In contrast, they spoke of their current lives, as mothers or pregnant women, as radically altered "for the better." These accounts illustrated how important they felt it was to distance themselves from the stigmatized figure of the "junkie" in order to stake their claim to "normal" motherhood (Radcliffe, 2011, p. 987). They also illustrated some of the broader objectives that people often hoped to be able to achieve through their engagement in drug treatment (Neale, Nettleton, & Pickering, 2011): improving their relationships with others, taking better care of themselves, and eventually living in their own home and finding a job or returning to school.

Jacqui, who was 23 years old and eight months pregnant with her first baby at the time of our interview, talked at length about how much her life had changed since she approached WADS during her first trimester. Jacqui made it clear that the reason she stopped injecting drugs was to do what was "best" for her baby—but she also described how much better doing so had made her feel "in herself."

> I see, like kids, like people my age, that are doing what I used to do and I just look down at them now. I think, 'I used to be like that.' I feel better in myself knowing that I'm not like that anymore.

Jacqui also found that her relationship with her boyfriend, Ryan, was much improved. She said they used to fight constantly, usually about money and drugs.

> I keep saying to him: 'I'm so glad I'm out of this scene.' Every time I see a person or a couple that are on it and that, I just think, 'I'm so glad I'm not "them" any more.' Like, we used to fight, like walking down the streets, like swearing at each other... It doesn't look attractive at all.

Jacqui had previously had an abortion and, more recently, suffered a miscarriage; she saw her pregnancy not only as an opportunity, but also as a sign that she and Ryan were meant to turn their lives around.

Women also repeatedly spoke of the kind of childhood or "life" that they wanted to provide for their babies. This theme has not frequently been observed elsewhere in the literature. The focus of these discussions was rarely on basic necessities—clothing, feeding, or housing, for example—but making sure that the baby, as a future person, would be happy, experience stability, and feel loved. One young woman, Lily, admitted to wanting to use drugs again, but said she was committed to staying "clean" for the sake of her two-month-old daughter:

> Before I had no one to care about. No one depended on me, or relied on me, you know. But she does completely, and she doesn't have a dad so if I go back and use full-on and something might happen to me, she would have no one [...] She deserves a mother that can give her the best, you know. Like every kid deserves a decent childhood, you know. If their parents are addictive, you know, to other drugs, alcohol, gambling, they can't give everything to their kid.

In some cases, women's own life histories and difficult childhoods seemed to inform these discussions. Ange, for example, described her son as a "new person in the world" for whom she hoped to provide a "good life":

> You want to start fresh, like because there's a new person in the world, you want everything to be... perfect. Like, as soon as he starts understanding and everything, his life should be pretty good so I have to make it good for him. And I wanted to do that as soon as he was born [...] I don't know... You try and not make their life crap; just 'cause I had a crap life doesn't mean that he has to.

Ange and others saw drug use as an impediment to having a "good life," because they took it for granted that being trustworthy and dependable would be impossible while maintaining a serious drug habit. As Sarah articulated at one point:

> My mum used, so I wasn't going to put him through the same thing... I want him in a role where I'm the mother, not he's looking after me, sort of thing.

Similarly, Jacqui summarized her reasons for seeking drug treatment as follows:

> I want the best for my baby. I don't want him to have a druggie mum or a druggie dad. I know I wouldn't have liked it so, you know. And I want to take care of him as best as I can and the way to do that is just to get off everything.

The findings summarized thus far suggest that majority of women in this study were highly motivated to do what was "best" for their babies. Many also often hoped and expected that becoming a mother would be a "turning point." They imagined that engaging in drug treatment would enable them to stop injecting drugs, and that this, in turn, would improve the quality of their relationships with others, repair or restore their sense of self-worth, and allow them to live more meaningful, stable, and secure lives. They also hoped or imagined that they would become someone that their babies could trust and depend on and in so doing, provide their babies with a "good life." For the most part, women seemed to take for granted that they would be able to meet each of these goals by accessing the support of the WADS clinic and getting or staying "stable" on OST.

At the same time, their accounts drew attention to certain problematic aspects of the care they received, which in some cases, seemed to confound their expectations of drug treatment. The clinic's drug treatment protocols, for example, were sometimes contrary to what women considered to be in the baby's best interests. Several women raised the issue of wanting to reduce their methadone dose as much as possible by the third trimester, so the baby would not

suffer from withdrawal symptoms at birth. However, it seems that none were encouraged to pursue this course of action.

Similar to a number of other women, 22-year old Taylor, who was six months pregnant with her second child, experienced this as a source of distress, believing her baby's health was being compromised for her sake:

> I'm basically poisoning baby through me having to stay straight. I'm a little bit... agitated [with] myself for it. But I can't beat myself up too much because yeah, it's keeping me off heroin so therefore, yeah.... And they say that most babies—some babies... I'm hoping that this baby will be a baby that won't be sick.

This passage illustrates how sensitive some women were to the idea that any ongoing drug use on their part—even that which had been therapeutically sanctioned—might be doing harm to the baby. It also illustrates women's desire to better understand neonatal abstinence syndrome and its causes, and their consequent concerns about OST.

I heard a number of accounts that reflected a similar degree of confusion or uncertainty about the effects of different substances during pregnancy, and what constituted "safer" use. This phenomenon was likely linked to another critical finding in this study: that among the few women who indicated that they had yet to stop injecting drugs, only one was willing to discuss this matter with the staff of WADS, and even she intimated that she had not disclosed the full extent of her ongoing use. It seemed, in other words, that women were reluctant to ask the clinics' prescribing doctors or other staff members about the effects of different drugs and drug-taking practices, nor were they provided with this information as a matter of course.

Women often relied instead on advice from their friends and/or improvised their own approach to harm reduction. Kendell, for example, explained that she stopped injecting speed and started injecting her boyfriend's buprenorphine during her first trimester, because she was worried about speed's effect on the baby but was not able to endure the symptoms of withdrawal. She did not have any input from WADS on this course of action because a friend whose baby had been apprehended by child protective services shortly after he was born, warned her not to say anything about her drug use. Kendell consequently had no intention of telling the clinic that she was injecting buprenorphine, nor that she planned to get "clean" by the time her baby was born.

Another factor that contributed to a failure to disclose was women's concern that they would be perceived as needing more help or information—and that this might imply they were unprepared for motherhood. Kelly, who was six months pregnant, explained to me that she decided to keep her baby because she wanted her own family and "the love and security" that families bring; she worried, in retrospect, that this desire had been "selfish." This fear arose because Kelly was homeless and awaiting the outcome of a public housing application. She also did not know who her baby's father was, and, in her words, was not "as stable" as she "should be." At several points during our interview, Kelly expressed feelings of guilt and remorse for continuing to inject drugs, as well as worry that she would ultimately "let down" her baby:

> I'm just so scared, Fiona. I'm just so scared that I'm not going to get a house in time. That I'm not going to get all these things ready in time. And how, you know? I don't even work. I haven't even got a fucking job.

When I asked Kelly if she had discussed these concerns with the staff at WADS, she replied:

> Kelly: I'm afraid to. I'm afraid that they'll get the welfare—
> Fiona: This is Child Protection?
> Kelly: That's why I don't want to. I'm afraid that they'll try and take him off me, or something, straight away as soon as he's born. I'm really afraid of that. So I don't want to tell, you know, about how I feel or how things are. And yeah, it puts me in a weird situation, in a weird spot because I need their help, but I don't need that— I need their help so that nothing like that will happen.

Similar to women identified in other studies (Klee et al., 2002), Kelly presumed that asking for help would compromise her future relationship with her baby and her hope that becoming a mother would be a "turning point" in her life, which, in turn, made her reluctant to attend antenatal appointments at the clinic.

Kelly's account reveals another noteworthy finding in this study, which was how few women seemed to comprehend how the child protection system worked and on what basis a notification or possible intervention might be made. When women who had not had any previous dealings with child protection services talked about "doing what it takes" to maintain custody of the baby, they often focused on drug use alone, overlooking other factors—like housing or the timing and frequency of their attendance at WADS—routinely assessed as per the clinic's mandatory reporting requirements. Remarkably, women who had previously experienced custody loss seemed no more informed about the risk assessment process. This left some feeling deeply insecure about their futures. Leanne, for example, was afraid that she would lose custody of her second baby even though she was adamant that she "never ever" wanted to "go near" heroin again. This fear stemmed in part from the ongoing judgment and scrutiny that Leanne experienced in her dealings with the Department of Human Services:

> I have a feeling that it's not going to be easy with this one either. Because it's constantly: 'How are you feeling about this baby? Is everything going to go all right with this baby? Is everything going to be fine with you and drugs? Is everything going to be *all right*? Are you sure you're going to be able to *handle* this baby? Is everything going to be *fine*? You're not going to go and meet all the people who you were with last time?'. I don't want to be around that anymore and people don't understand that. I've seen what I've done wrong. I know what I've done wrong.

Unlike Kelly, Leanne was stably housed, in a relationship with a non-drug-using partner, and appeared to be following drug treatment protocols. Nevertheless, she felt demoralized by her interactions with certain child protection caseworkers—and having limited knowledge about the risk assessment process left her feeling powerless.

Finally, some women experienced the procedures followed at the hospital to treat NAS as punitive and destabilizing. Much of my discussion with Lily, for example, centred on the experience of having her newborn baby girl placed in the hospital's Special Care Nursery for six weeks after her birth in order to be stabilized on morphine. Lily said that during this

period she decided to "get off everything." That is, to stop taking Valium and speed and smoking marijuana. She described this decision as follows:

> I don't know how to describe it, but she was in intensive care for the first couple of days and then they brang her down to my room and I thought that was great. But then she stayed down in my room for three days, but then they brang her back up to intensive care and put her on morphine and I felt like they did it on purpose or something, you know? She obviously needed to be on it, but I don't know how much she really needed to be on it or how much, you know, they wanted to put her on sort of to teach me how to be a mum.

What was striking about this story was how keenly Lily felt the loss of her daughter when she was removed from her care. It was also striking how much this experience seemed to exacerbate Lily's feelings of guilt for using drugs during her pregnancy:

> Lily: Like, I feel like the staff in the ward, they looked down on me because she was born addicted to drugs, had to be put on morphine, you know. And if I wasn't using and on methadone she never would've had to be in that situation. So I really felt like they blamed me, you know—I blame me, you know.
>
> Fiona: You do?
>
> Lily: Yeah, of course.
>
> Fiona: Is that feeling kind of going away a bit now that you're here with her and taking care of her?
>
> Lily: Um, yeah, I guess, yeah. I don't know—yeah—
>
> Fiona: You're not sure?
>
> Lily: Yeah.

It seemed as though Lily's obvious care and concern for her baby was neither acknowledged nor affirmed by the hospital staff, whom she perceived as patronizing and determined to "teach" her "how to be a mum" by punishing her through the temporary removal of her baby from her care.

Addressing the Barriers to Care in Specialist Maternity Services

The findings discussed in this chapter illustrate that pregnant women's expectations of drug treatment are complex and multifaceted. Most women wanted to achieve fairly tangible goals; they sought professional guidance and support to minimize the effects of their drug use on the baby, to maintain custody of the baby, to stop or substantially reduce their injecting drug use, and/or to effect other changes in their lives, like improving their relationships with their partners. According to many women, achieving these goals would also mean something significant about who they were, that they were willing and able to "do what was best" for their babies and therefore would become "normal," as opposed to "druggie," mothers. A significant number of women also imagined that not having to maintain a serious drug habit

would allow them to share a close relationship with their babies and thus give their babies the kind of life that they deserve.

These expectations also help to explain why a significant number of women considered problematic certain aspects of the care they received in the WADS. In particular, women's concerns about the baby's health and development sometimes translated into a desire to avoid NAS, which ran contrary to the clinic's aim to maintain women on a high enough methadone dose to prevent maternal withdrawal. Most women also desperately wanted to maintain custody of their babies, which paradoxically prevented some from seeking the support they needed, to find stable housing—as well as more information to help them engage in safer drug taking practices. Finally, women's desire to "be there" for their babies was also sometimes complicated by their engagement in drug treatment, insofar as they imagined seeking treatment made it more likely that their babies might be apprehended. Being in treatment also meant that their babies were sometimes removed from their care and placed in the hospital's neonatal intensive care unit.

One of this study's more significant findings is that both "compliant" and "non-compliant" clinic clients expressed serious misgivings about the possibility that their involvement in treatment could lead to their losing custody of their babies. While similar results have been interpreted elsewhere to indicate that the anxiety provoked by the child protection system is "somewhat unrealistic" (i.e., unfounded in practice) (Tobin, 2005, p. 66), there is contrary evidence both of the system's lack of transparency and its tendency toward "over-inclusion," where women become subject to investigation simply by virtue of the fact that they are on OST or because they have been involved with child protective service in the past (Chandler et al., 2013; Lean, Pritchard, & Woodward, 2013; Valentine & Treloar, 2013). The findings of this study and others (Radcliffe, 2011) suggest that pregnant women are rarely given as much information as they want or need about the precise circumstances under which an intervention by child protection authorities might be made. In the very least, more information could be provided about the formal protocols that drug treatment services use when making a notification to child protective services.

The findings of this study also suggest that women are reticent to disclose their ongoing drug use to staff of specialist maternity care services out of fear of child protection, and that staff, in turn, are often reticent to provide women with information about the range of strategies beyond OST that they could use to minimize the harms associated with substance use during pregnancy. Providing this kind of advice or guidance would be particularly beneficial in the event that pregnant women are unable or unwilling to cease their injecting drug use entirely. Recognizing that women continue to use other drugs while on OST and providing information to mitigate harm would likely signal the non-judgmental attitude that is said to be integral to retaining pregnant women in care. Certainly there is an extensive evidence base—at least about the short- and long- term effects of using different substances during pregnancy (Unger et al., 2011) and the factors likely to contribute to NAS (Cleary et al., 2010; Pizarro et al., 2011; Thajam, Atkinson, Sibley, & Lavender, 2010)—to provide this kind of information. In its absence, many pregnant women will likely not disclose the full extent of their drug use or the ways in which they might be modifying their use in order to protect their fetus.

Based on the insight that many pregnant women want to align themselves with the normative identity of the "good" mother, previous studies recommend that drug treatment providers do more to validate any and all efforts women make to provide for and nurture their

babies (Banwell, 2003; Klee et al., 2002; Murphy & Rosenbaum, 1999; Radcliffe, 2011; Taylor, 1993). The findings of this study support this recommendation to an extent. At the same time, the women in this study seemed to interpret "good" motherhood in a very particular way, as someone who was both physically and emotionally available to her children. Therefore, it was not only validation or recognition that women seemed to need, but rather opportunities to form a close, intimate bond with their babies. A simple way such an opportunity could be provided would be allowing newborn babies to "room in" with their mothers, even if they exhibit symptoms of NAS. Evidence suggests that doing so might help reduce the prevalence and severity of NAS and also increase the likelihood of babies being discharged in the care of their mothers (Abrahams, Kelly, Thiessen, Mackintosh, & Janssen, 2007).

CONCLUSION

This chapter has engaged in a comparative examination of pregnant women's expectations of drug treatment and the structure and organization of specialist maternity care in Australia—a model also found in other countries, including Canada. This examination has illustrated that pregnant women are often highly motivated to access drug treatment services, but these motivations are sometimes confounded by the multiple roles played by practitioners in specialist maternity care and the sometimes conflicting priorities of pregnant women and caregivers. Addressing this issue is vitally important. OST and specialist maternity services both have the potential to achieve a number of positive outcomes for both women and their babies, including better management of the various harms associated with illicit drug use (Greaves & Poole, 2007) and increasing the likelihood of women retaining custody of their babies (Gilchrist & Taylor, 2009). These outcomes are contingent, however, on women's retention and engagement in drug treatment services, which depends, in turn, on whether or not women consider the services that they have access to beneficial. This is more likely if drug treatment services take seriously the various challenges, concerns, and expectations that pregnant women bring with them into the treatment encounter.

My aim in this chapter has not been to suggest that all women want to stop injecting drugs when they are pregnant or that disengaging from injecting drug use is, by any means, a straightforward process that hinges on whether or not women have access to effective drug treatment supports.[15] On the contrary, I have tried to demonstrate that women often seek drug treatment services during pregnancy for a range of different reasons, which do not always correspond with the objectives of service providers. The complex reality is that two fundamental objectives of specialist maternity services are to maximize healthy birth outcomes and to protect the needs of children. These goals compromise the ability of these services to meet another key objective: adopting a harm reduction approach by providing pregnant women with supportive and non-judgmental care based on an understanding and acknowledgement of their sometimes complex life circumstances.

[15] As I have argued elsewhere (Martin, 2011), a number of other factors—including feelings of ambivalence—can and do complicate the process of disengagement for pregnant women and mothers, especially beyond pregnancy and the immediate post-partum period.

These objectives might be brought into closer alignment by offering pregnant women more concrete information about how to reduce the harms associated with using different drugs during pregnancy. It should also be possible to inform women how risk to the baby's wellbeing is assessed and what precise procedures will be followed if child protection services are notified. It would be even more helpful if specialist maternity services broadened their mandates and consistently provided pregnant women with practical and material supports, including access to stable housing. This evidently depends on how resources are allocated and which objectives are prioritized. As Benoit et al. argue, opportunities to enact and sustain a harm reduction or "participant-centered" approach are constrained by the other priorities of drug treatment services, as well as the limited resources made available to address the socio-structural origins of health (2014, p.261). Further research and advocacy is necessary, therefore, to continue to improve pregnant women's access to and experiences of supports like OST and specialist maternity care, and to implement a broader approach to harm reduction for this group.

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